“Ella Se lo Buscó”: Marianismo as a Cultural Vehicle for Self-Invalidation among Latina Survivors of Sexual Violence

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MARIANISMO AND SELF-INVALIDATION IN SURVIVORS

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Author’s Note

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Abstract

Sexual violence (SV) survivors are often confronted with hostile environments that perpetuate victim-blaming attitudes. One common response to SV is self-invalidation; whereby, survivors deny, neglect, minimize or judge themselves and their experiences via feelings of self-blame, shame, taintedness, and anticipatory stigma. Research suggests that patriarchal gender-based values like marianismo are prevalent in Latinx communities and that Latina survivors are at increased risk for self-invalidation and mental illness. Consequently, it is imperative to examine cultural mechanisms that may contribute to these negative outcomes among Latina survivors. This study’s objectives were threefold: (1) examine ethnic differences in self-invalidation between Latina and White survivors; (2) examine the mediating effect of marianismo on the link between ethnicity and self-invalidation; and (3) test the hypothesis that self-invalidation uniquely predicts survivors’ negative mental health outcomes. Participants (N = 129) recruited via Prolific, who identified as Latina or non-Latina White survivors of male-perpetrated SV completed questionnaires assessing marianismo beliefs, mental health outcomes (PTSD, depression, anxiety), assault and disclosure experiences, and post-assault self-invalidation. Results revealed high rates of self-invalidation and low rates of marianismo among Latina and White survivors. Importantly, marianismo positively predicted survivors’ self-invalidation, which in turn predicted increased risk for PTSD, depression, and anxiety. These findings suggest that survivors across cultures may be internalizing the invalidating messages they receive from their environments and that the subsequent experience of self-invalidation exacerbates their mental illness. Implications for discerning contemporary forms of marianismo, understanding the debilitating impact of self-invalidation, and developing culturally responsive interventions for Latina survivors are discussed.

Keywords: self-invalidation, sexual violence, marianismo, Latinas, mental health
“Ella Se lo Buscó”: Marianismo as a Cultural Vehicle for Self-Invalidation among Latinas Survivors of Sexual Violence

There is a pressing need to expand the literature on the intersection of culture and sexual violence (SV), especially among Latina survivors (Sierra, 2020; Torres, 2017). The bulk of the research on predictors of survivors’ mental health has been limited to investigating the impact of individual-level (i.e., victim demographics, nature of assault) and social support (i.e., disclosure) factors on post-assault outcomes, whilst neglecting the influence of contextual factors in shaping the survivor experience (Bryant-Davis et al., 2009; Campbell et al., 2009). Furthermore, although studies have documented the detrimental mental health outcomes associated with post-traumatic self-invalidation, little attention has been given to addressing the ways in which cultural values may shape or elicit self-blame and shame in Latina survivors, in the first place (Kennedy & Prock, 2016; Neville & Heppner, 1999; Nuñez et al., 2016).

To address this gap in the literature, the present research utilized a sample of Latina and non-Latina SV survivors to explore the relationship between adherence to marianismo, and Latinas’ increased risk for post-assault self-invalidation and for developing negative mental health outcomes. The machismo-marianismo dyad reflects Latino values that describe idealized traditional gender roles and prescribe behavioral and attitudinal mandates for men and women. Whereas machismo underscores male toughness, aggression, protectiveness, sexual prowess, and subordination of women (Nuñez, et al., 2016), marianismo rewards women’s self-sacrifice, self-renouncement, passivity, sexual repression, and deference to male authority (Castillo et al., 2010; Da Silva, et al., 2021). Marianismo is thus believed to be a cultural factor with important consequences for a Latina survivor’s post-assault experiences.
Accordingly, this review of the literature will begin by examining the negative sequelae associated with sexual victimization and propose an ecological framework with which to understand these outcomes with greater nuance. It will then discuss the ways in which marianismo may serve to compound the impact of sexual trauma, facilitate self-invalidation, and exacerbate negative mental health outcomes among Latina survivors.

**Sexual Violence is Pervasive and Associated with Negative Mental Health Outcomes**

Sexual violence (SV) against women is a ubiquitous public health problem that affects survivors from all around the world. Systematic reviews conducted on samples of European, African, Asian, and Latin American survivors reveal that worldwide *past-year* prevalence rates for SV among women range from 0% to 59.2% (Dworkin et al., 2021). Furthermore, the global *lifetime* prevalence of SV has been estimated to be around 7.2%, with the highest lifetime rates found in Africa (4.5%–21.0%), and lower rates found in other regions (16.4% for Australasia, 5.8–15.3% for Latin America, 13.0% for North America, 6.9–11.5% for Europe, and 3.3–12.2% for Asia; Abrahams et al., 2014).

Within Latin America, SV is disturbingly endemic to Mexico, a country whose deeply entrenched history of domestic violence and gender inequalities has culminated in its rampant femicides, which take the lives of 10 women every day (Calderon et al., 2020). Indeed, Mexico saw 22,379 cases of sexual abuse and 12,320 cases of rape only in 2021 (Calderon et al., 2020). Research suggests that these figures may be severely underestimating SV in this population given that an alarming 98.6% of SV cases among Mexican women go unreported (Instituto Nacional de Estadística y Geografía, 2020). Furthermore, Mexican survivors are increasingly reluctant to seek formal services. For example, in a national survey, less than 1% of Mexican...
female rape survivors sought help from public health services, and only 8.37% sought help from law enforcement (Frias & Ríos-Cázares, 2019).

Exposure to sexual victimization is associated with a host of deleterious mental health outcomes including an increased risk of developing PTSD, and higher reports of depression, anxiety, and disordered eating (Bryant-Davis et al., 2009; Dworkin et al., 2017; O’donohue & Schewe). For example, in a qualitative review of psychiatric outcomes in SA survivors, between 17% and 65% of survivors developed PTSD, 13%–51% were diagnosed with depression, and 12–40% presented with anxiety symptoms (Campbell et al., 2009; Dworkin et al., 2017). Moreover, survivors are increasingly at risk for suicidal behavior and dependence on alcohol or illicit substances. Uniquely, Latinas often report greater suicidal ideation, suicide attempts, substance use, and peritraumatic dissociation when compared to their White counterparts (Bryant-Davis et al., 2009; Krishnan, Hilbert, & VanLeeuwen, 2001; Kaukinen & DeMaris, 2005). Lastly, it is well-established that severe and chronic interpersonal trauma can result in Complex PTSD, a condition marked by core posttraumatic stress symptoms, in addition to disturbances in the self-organization (i.e., emotional dysregulation, negative self-concept, and interpersonal difficulties; Villalta et al., 2020).

In light of this wide range of trauma sequelae and in an effort to understand survivors’ varying posttraumatic trajectories, many studies have focused on identifying the factors that place survivors at risk for developing post-assault mental illness. Specifically, the empirical literature has primarily focused on three predictors of negative psychological sequelae: survivor demographics, assault-related factors, and disclosure experiences. Although there are inconsistent findings pertaining to the demographic correlates of PTSD (e.g., age, income employment), some studies report greater PTSD severity among less educated and ethnic
minority women (Campbell et al., 2009; Ullman & Filipas, 2001; Cuevas et al., 2010). In particular, when compared to other ethnic groups, Latina women report the highest rates of PTSD and depression, lower self-esteem, and greater victim-blaming disclosure experiences (Cuevas et al., 2010; O’Callaghan & Ullman, 2022). With respect to assault-related factors, higher levels of PTSD, anxiety, and depression tend to be found among victims of assaults characterized by greater degrees of assault severity, offender violence and force, repeated victimization and in cases perpetrated by strangers or relatives (Kimerling et al., 2007; Ullman & Filipas, 2001; Ullman et al., 2006; Ullman et al., 2007). Lastly, the literature on assault disclosure establishes that receiving negative reactions (e.g., victim-blaming, distraction, egocentrism) from both formal and informal sources is associated with greater PTSD, depression, and anxiety symptomatology (Campbell et al., 2009; Peter-Hagene & Ullman, 2014; Ullman & Filipas, 2001).

Understanding the Survivor Experience Necessitates an Ecological Framework

Unfortunately, in placing a disproportionate focus on victim demographics, assault, and disclosure factors when studying post-assault trajectories, the scholarship has fallen short of understanding the nuances of the survivor experience, and the unique challenges faced by ethnic minority victims. By failing to address the sociocultural context in which SV occurs, past studies have neglected the central role of a survivor’s culture in compounding experiences of sexual trauma and shaping patterns of distress and recovery (Bryant-Davis et al., 2009). Because SV is culturally situated and occurs at the intersection of societal traumas like sexism, patriarchy, and racism, it is imperative that trauma scholars employ ecologically informed frameworks to guide research efforts and inform culturally sensitive interventions (Campbell et al., 2009). Only by accounting for the psychological effects of cultural factors that predate the assault and color the
experiences of survivors can clinicians begin to fully address the mental health needs of ethnic 
minority victims like Latinas. For this reason, the present research sought to adopt an ecological 
lon that would permit an examination of the ways in which prevailing Latino beliefs and values 
influence Latina survivors’ perceptions of their experiences and affect their mental health.

The ecological theory of SA is founded on the premise that SA survivors will present 
with differential post-assault outcomes as a function of their distinct ecological settings. Neville 
and Heppner’s (1999) Culturally Inclusive Ecological Model of Sexual Assault Recovery 
(CIEMSAR) posits that a survivor’s mental health and recovery process is influenced by factors 
beyond the assault itself and the victim’s individual characteristics (Neville & Heppner, 1999). 
Specifically, it postulates that culture permeates and influences the entire recovery process and 
that a survivor’s negative mental health sequelae are shaped by multiple factors located within 
three primary systems of their social ecology (Neville & Heppner, 1999). The microsystem is 
comprised of individual-level factors including survivor demographics (e.g., age, race, income, 
education) and assault-related factors (e.g., relationship to perpetrator, physical injury, age at 
incident). The mesosystem is characterized by social support factors including the survivor’s 
social networks and experiences with disclosure. Finally, the microsystem and mesosystems are 
theorized to be nested within a broader macrosystem of the cultural values, societal norms, 
practices, and rhetoric around SV that compose a culture (Neville & Heppner, 1999) and 
contribute to a victim-blaming environment.

Drawing on this framework, one cultural mechanism within the macrosystem that can 
exacerbate negative mental health outcomes, and that is salient to the Latina SV experience is 
sexual violence-supportive norms. These norms comprise normative beliefs about SV, sex, and 
gender that are culturally held and that promote victim-blaming messages whilst perpetuating
rape and hostile attitudes about women’s rights and roles (Dworkin & Weaver, 2021; Suarez & Gadalla, 2010). Examples include traditional gender roles and patriarchal values that privilege men’s status over women and normalize women’s subordination, as well as societal rape myth acceptance (e.g., believing in “victim precipitation” or the notion that survivors provoke their assault). In researching ethnocultural predictors of survivor mental health it is important to examine cultural variations of sexual-violence supportive norms given that they may elicit or confirm trauma-related cognitions (e.g., “It was my fault” “I am ruined”) that maintain or amplify mental illness (Lira et al., 1999).

Marianismo Normalizes Latinas’ Abuse and Self-Sacrifice and Elicits Negative Sequelae

There is a dearth of literature on the lived experiences of Latina survivors. This gap is especially notable with regard to the role of contextual factors like cultural values in shaping how Latinas make sense of and attribute blame for their assault. Nevertheless, the available research suggests that sexual-violence supportive norms are ethnographically manifested among Latinas in the form of marianismo. As previously mentioned, marianismo is a Latina-specific culture value system, which prescribes a set of cultural directives expecting Latinas to embody traits of passivity, self-sacrifice, chastity, sexual suppression, interpersonal harmony, and obedience to men (Castillo et al., 2010; Da Silva, et al., 2021).

The studies that have examined Latinas’ adherence to marianismo beliefs have found that, within samples of predominantly Mexican American immigrants, there is an inverse relationship between acculturation and marianismo endorsement (Cano, 2003; Jezzini, 2013; Murguia, 2001; Nuñez et al., 2016; Ruiz-Balsara, 2001). One relevant implication of these studies is that marianismo may be more prevalent among Latinas who are residing in their native
Latin American countries. This body of research has also shown that women who are older, Catholic, and less educated endorse more of these beliefs (Ruiz-Balsara, 2001; Vazquez, 1998).

Particularly noteworthy is a qualitative study that employed semi-structured interviews to examine differences between seven Mexican and seven Mexican American women in their perceptions of a woman’s role. In this study, Vazquez (2007) found that Mexican women often defined a “good woman” as one who was a dedicated and sacrificial wife and mother, and who always put others’ needs before her own. In contrast, Mexican American women emphasized the virtues of self-respect, being a responsible mother, and being willing to compromise without sacrificing themselves (Vazquez, 2007). These differences suggest that, compared to Mexican Americans, Mexican women may have a greater affinity to traditional marianismo beliefs that underscore a woman’s duty to surrender or negate her needs in favor of those of her partner or children. This assertion is consistent with the finding that the marianismo beliefs that Latinas endorse the most are those linked to tenets of self-sacrifice and self-abnegation, rather than those associated with submission and chastity (Cano, 2003; Murguia, 2001).

Considering that some of the central themes surrounding marianismo include a commitment to oblige male desires, remain chaste until marriage, withstand suffering for the sake of the family and withhold thoughts to preserve harmonious relationships (Castillo et al., 2010), it is critical to explore how adherence to marianismo can influence Latinas’ experiences of and attitudes towards SV. Researchers have posited that because marianismo normalizes male assertions of power while advancing notions of honorable women as those who endure suffering and remain committed to their husbands, a high endorsement of marianismo could help explain why Latinas choose to stay with their abusers, and their inability to recognize abuse or perceive it as problematic (Perilla et al., 2012; Villanueva, 2012). At the same time, although some
Latinas may be led to perceive SV as normative, others who endorse marianismo beliefs that place a high value on chastity may be profoundly affected by SV. That is, a Latina’s victimization may simultaneously force her to cope with the traumatic desecration of her intimacy and with the implications of having violated culturally valued gender norms.

To this author’s knowledge, only four studies to date have evaluated marianismo beliefs in survivors of intimate or interpersonal trauma. In one study conducted on 47 Honduran IPV survivors, Sierra (2020) found no statistically significant relationship between adherence to marianismo and IPV. However, the remaining three studies provide support for the potential negative impact of being victimized within a context of patriarchal values. For example, in a qualitative study on 32 IPV survivors who were HIV+ and came from Puerto Rico, Dominican Republic, Mexico, South, and Central America, Moreno (2007) found that marianismo beliefs placed Latinas at risk of experiencing IPV and contracting STIs and HIV. More specifically, adherence to marianismo was associated with women’s normalization of abuse, which hampered their ability to abandon abusive relationships and risky situations. Marianismo also elicited feelings of sexual shame, which explained women’s inability to speak frankly about sex with their partners because “it’s not a Latina’s place to talk openly about sex.” (Moreno, 2007, p. 345). The implication of this study is that marianismo adherence may discourage Latina survivors from negotiating safe sex whilst also encouraging a Latina’s toleration of SV.

With respect to mental health outcomes, Torres (2017) found that marianismo was a significant predictor of women’s PTSD symptoms in a sample of 157 Latinas who were college students in the United States. Consistent with these findings, in another study conducted on 205 predominantly Cuban and Colombian IPV survivors, Da Silva et al. (2021) found that Latinas who endorsed greater marianismo beliefs associated with the belief that women should respect
patriarchy, submit to men’s needs and hold back their opinions reported higher levels of psychological distress. *Marianismo* has also been linked with increased depression, anxiety, and cynical hostility among Latinas overall (Jezzini, 2013; Murguia, 2001; Nuñez et al., 2016; Vazquez, 1998). Together, the available research suggests that a higher endorsement of *marianismo* may exacerbate the psychological impact of sexual trauma and elicit negative mental health outcomes in Latina survivors.

**A Latina’s Internalization of Marianismo Facilitates Shame and Self-Blame**

A vast body of research reveals that survivors across ethnicities present with a cluster of symptoms related to an injured sense of self. Following SV, survivors often endure serious damage to their self-concepts, experiencing pervasive self-devaluation in the form of self-blame and shame (Kennedy & Prock, 2016). For example, in a sample of ethnic and racial minority survivors, Vidal & Petrak (2007) found that around 75% of women reported assault-related shame, which was in turn associated with greater self-blame and traumatic stress.

Evidence suggests that Latina survivors are at increased risk of experiencing self-blame and shame. Kellogg & Hoffman (1995) found that Latinas were more likely to report self-blame than non-Latina White and African American survivors. Corroborating these findings, studies indicate that Latina survivors report higher PTSD rates than White and African American women (Bryant-Davis et al., 2009) and that these elevated PTSD levels can be partially explained by their tendency to self-blame (Pole et al., 2005; Wolfe et al., 1994). To a Latina, the gendered and sexual nature of SV can carry such significant implications for her honor and femininity, that even decades after experiencing extramarital rape, she may continue to endure a wholly sense of unworthiness, and define her entire being as defiled (Fontes, 2007).
Importantly, the cultural backdrop of marianismo can help explain Latinas’ tendency to present with shame and self-blame, given that marianismo can promote survivor-stigmatizing and victim-blaming attitudes. If a survivor has internalized the belief that a woman’s value hinges on her virginity and that she ought to make herself sexually inaccessible, it is more likely that she will blame herself for the abuse, and experience societal blame and stigma if the abuse occurs outside marriage. Consistent with this assertion, in a study on 101 female rape victims, Lefley et al. (1993) found that, upon reading different scenarios of coercive sex (e.g., date rape, use of force, sex worker victim) and answering questions about their beliefs in sexuality, Latinas were more likely than White and African American survivors to attribute blame to victims, both in reference to themselves and other women, whereas White survivors were the least victim-blaming. Relatedly, Latinas were also the most likely to perceive their ethnic community as more victim-blaming and reported the highest (and White survivors the lowest) psychological distress. In other words, Latinas engaged in more self-blame, espousing rape myths that women contribute to their assault through dress and behavior and are responsible for controlling men’s unbridled sexualities (e.g., “Men sometimes have sex urges they can’t control, especially when they see women dressed in sexy clothing”; Lefley et al. 1993, p. 627).

The implication of this foundational study is that Latinas may be internalizing cultural and gendered attitudes that facilitate shame and self-blame responses. Specifically, Latinas’ negative post-assault sequelae and damaged self-concepts may reflect their internalization of marianismo, such that Latinas are “particularly traumatized by rape because of a greater tendency to view themselves as both culpable and tainted by sexual assault” (Lefley et al. 1993, p. 629). Consequently, the Latina SV experience may be traumatic not only due to the frightening and denigrating nature of the crime but also because Latinas must confront hostile
cultural norms that excuse their abusers whilst leaving them feeling blameworthy and condemned to their core (Kennedy & Prock, 2016).

**Post-Assault Self-Invalidation is Debilitating and Exacerbates Mental Illness**

*Self-invalidation* is a composite construct that encapsulates Latinas’ pervasive experiences with shame and self-blame following SV. Self-invalidation describes a form of self-negation whereby survivors deny, neglect, minimize or judge themselves and their traumatic experiences. This response may result from the individual’s internalization of damaging messages from invalidating environments (Linehan, 1997).

Within the SV literature, self-invalidation as a posttraumatic response is often represented by the term internalized stigmatization, which comprises two central components: *self-blame* and *internalized stigma* (i.e., feelings of shame, feeling innately tainted and anticipating societal stigma) (Kennedy & Prock, 2016; Finkelhor & Browne, 1985). Accordingly, a SV survivor can be said to self-invalidate whenever she attributes blame for the assault to herself (self-blame), and/or if she feels ashamed of her person, innately debased, or espouses the belief that she will be stigmatized upon disclosure of her assault (Dorahy et al., 2013; Kennedy & Prock, 2016).

From an ecological perspective, because stigma may be reinforced by societal messages that the survivor receives or infers from her community (Campbell et al., 2009; Finkelhor & Browne, 1985), *marianismo* may trigger or increase self-invalidation in Latina survivors, and thus elicit poor mental health outcomes.

A growing body of research has found that self-blame and shame (self-invalidation) predict a variety of negative outcomes including higher PTSD, depression, anxiety, emotional dysregulation, psychological distress, maladaptive coping, and reduced self-esteem in survivors (Gonzalez, 2022; Kennedy & Prock, 2016; Koss et al, 2002; Lefley et al., 1993; Messing et al.,
2014; Reich et al., 2015). Self-blame and shame responses are also associated with an increased risk of revictimization and with lower disclosure and help-seeking behaviors (Kennedy & Prock, 2016). Therefore, it is of particular concern that treatment outcome studies indicate that survivors’ negative self-concepts tend to be unresponsive to treatment. For example, although survivors treated with flooding and prolonged exposure show significant decreases in anxiety with increasing exposure, their feelings of shame and self-blame either persist or increase with time (Meadows et al., 1998; Pitman et al., 1991). For this reason, examining the cultural roots of Latinas’ self-invalidation and understanding its debilitating effects should be a priority when adapting treatment for Latina survivors and identifying potential risk factors among them.

Present Study

The current study had three primary aims. The first aim was to examine ethnic differences in self-invalidation between non-Latina White and Latina survivors of male-perpetrated SV. Given that Latinas may be at higher risk for self-blame and victim-blaming than non-Latina White survivors, and that their mental health consequences can be attributed to self-blame (Bryant-Davis et al., 2009; Kellogg & Hoffman, 1995; Lefley et al., 1993) it was hypothesized that self-invalidation would be greater in Latinas than non-Latina White survivors.

The second aim was to test whether marianismo has a mediating effect on the link between ethnicity and post-assault self-invalidation. Based on the literature that indicates that Latinas espouse more traditional gender role attitudes and rape myths than non-Latina White women (Kane, 2000; Lefley et al. 1993, Williams, 1984), and that marianismo attitudes normalize women’s subordination and thus may facilitate self-blame and shame responses (Da Silva, et al., 2021; Lefley et al. 1993; Moreno, 2007, Perilla et al., 2012), it was anticipated that marianismo endorsement would partially explain ethnic discrepancies in self-invalidation. That
is, Latinas were hypothesized to engage in greater self-invalidation as a result of endorsing marianismo beliefs to a greater degree.

The third aim was to examine the impact of self-invalidation on survivors’ mental health outcomes (i.e., PTSD, depression, and anxiety), over and above demographics, assault variables, and whether the survivor disclosed the assault. Prior studies suggest that self-invalidation predicts an extensive range of negative sequelae, with PTSD being more likely to be diagnosed in survivors who report shame and self-blame (Kennedy & Prock, 2016; Messing et al., 2014; Wolfe et al., 1994). It was thus expected that self-invalidation would increase the risk for PTSD, depression, and anxiety severity in survivors.

Taken together, it was hypothesized that Latinas would self-invalidate to a greater extent than non-Latina White survivors, as a result of higher marianismo endorsement, which, in turn, would be associated with more negative psychological sequelae. Marianismo beliefs create a cultural context wherein self-invalidating responses like shame and self-blame thrive given that they advance the harmful expectation that women inhibit their thoughts, withstand suffering, remain submissive, and defend an image of purity amidst sexual violation (Castillo et al, 2010).

Ultimately, this study has important implications for improving the effectiveness of interventions for Latina SV survivors so that they address cultural issues that are salient for this population. Specifically, this study may help shed light on the ways in which interventions may be adapted to (1) be responsive to gender-based values that are prevalent in Latinx communities and their role in shaping Latinas’ responses to SV, (2) facilitate awareness, understanding and more effective responses to the messages of invalidating environments, and (3) reduce unjustified emotions and self-invalidating beliefs whilst fostering self-validation in its place.

**Method**
Participants

Individuals who met the following eligibility criteria were invited to participate in the study: (1) 18 years or older, (2) self-identify as women, (3) endorsed having previously experienced sexual violence (4) reported that the sexual violence act was committed against them by a man, (5) endorsed being of either Latina or non-Latina White ethnicity, and (6) reported being fluent in English. Participants (N = 132) were recruited via Prolific, an online paid recruitment research platform, in which the Qualtrics survey link was embedded. Prolific has been demonstrated to yield less dishonest responses, produce higher quality data, and reach a more diverse population compared to other crowdsourcing platforms like Amazon Mturk and CloudResearch (Peer et al., 2017; Peer et al., 2022). Upon completion of the survey, participants were compensated for their participation with approximately $4.

Of the 132 total responses, only individuals with complete data were included in the analyses (n = 3 excluded for missing data due to item non-response). The final sample (N = 129) was comprised mostly of women identifying as cisgender women (96.1%), with 5 participants (3.9%) identifying simply as “female” or “woman”. Roughly half of the sample (n = 63, 48.8%) were women of non-Latina White ethnicity, and the other half identified as Latina (n = 66, 51.2%). Participants’ ages ranged from 19 to 72 and averaged 28.20 years of age (SD = 10.31). Participants were natives from countries across the globe. Specifically, most of the non-Latina White participants (85.7%) came from a variety of European countries including Portugal (28.6%), the United Kingdom (20.6%), Poland (6.4%), and Ireland (6.4%). A significant majority of Latina participants (89.4%) originated from Mexico, with the remaining seven coming from countries including Chile (4.5%), Colombia (1.5%), Peru (4.5%), Venezuela (1.5%), and the United States (1.5%). Most participants reported either being married/in a
relationship (47.3%) or being single (47.29%), and a majority (85.3%) fell in the low SES category. Half of participants had earned a 4-year degree or greater (50.4%) or reported having some college experience (29.5%). Lastly, participants most frequently identified as either Catholic (27.1%), agnostic (27.1%), or atheist (24.0%; see Table 1 for complete descriptives of participant demographics).

**Procedure**

The study utilized a cross-sectional survey research design, and participants were recruited via Prolific. Prior to choosing to register for the study, eligible participants were provided with a brief study description, informing them that the study aimed to investigate how female SV survivors perceive themselves and their unwanted experiences and that it would consist of questions regarding the nature of their experiences with SV and disclosure, and their perceptions about themselves. Participants were also informed that some of the items in the survey were sensitive in nature and would ask that they share information about past traumatic events that may be triggering to reflect on. Moreover, they were informed that they would be able to skip any questions pertaining to the nature of their unwanted experience and disclosure process that they found discomforting, and that they would be provided mental health resources at the end of the study if they wished to receive confidential support.

Interested individuals registered for the study on Prolific and were provided with a Qualtrics survey link in which they could access the survey. At the beginning of the survey, respondents were asked a number of screening questions to ensure that they qualified for the study. These included questions about whether they were 18 years of age or older, whether they self-identified as female survivors of male-perpetrated SV and as non-Latina White or Latina,
and if they were fluent in English. Individuals who answered “No” to any of the above inclusion criteria were informed of their ineligibility to participate in the study.

Participants who endorsed “Yes” to all inclusion criteria were asked to complete an informed consent form and were then directed to the remainder of the survey. The survey queried participants about their demographics, endorsement of marianismo beliefs, mental health symptoms (PTSD, depression, anxiety), the nature of their experiences with SV and disclosure, and their extent of self invalidation (see Measures section for complete details about items asked in each domain). Technical security measures (e.g., reCaptcha) and six quality-check questions were included throughout the survey to prevent fraudulent respondents and screen for low-quality data. Participants were required to pass at least four checks for their data to be included. Based on this criteria, no participants’ data was excluded from the study.

Upon conclusion of the survey, participants were debriefed on the purpose of the study and provided with an extensive list of free mental health resources if they desired follow-up care (i.e., Crisis Text Line, National Domestic Violence Hotline, National Sexual Assault Hotline, National Suicide Prevention Lifeline, After Silence Forum for Survivors of Sexual Violence).

Measures

Demographics

Participants completed a 9-item questionnaire, concerning their age, gender identity, race, place of birth, socioeconomic status, education level, marital status, and religious beliefs.

Marianismo

The Marianismo Beliefs Scale (MBS; Castillo et al., 2010) is a 24-item validated scale that assesses the extent to which Latina women endorse marianismo beliefs. The MBS comprises five subscales: Family Pillar (5 items), Virtuous and Chaste (5 items), Subordinate to Others (5
items), Self-silencing to Maintain Harmony (6 items), and Spiritual Pillar (3 items). In this study, only the 16 items on the Virtuous and Chaste (e.g., “A Latina should remain a virgin until marriage”), Subordinate to Others (e.g., “A Latina should not speak out against men”), and Self-silencing to Maintain Harmony (e.g., “A Latina should always be agreeable to men’s decisions”) subscales were used. These three subscales tap marianismo beliefs concerning women’s sexual and moral purity, obedience and respect for men, and inclination to subordinate personal needs to preserve interpersonal harmony, respectively. The response options are distributed on a four-point scale, ranging from 1 (strongly disagree) to 4 (strongly agree) and respondents rate the extent to which they agree with statements about a woman’s roles and values. Scores across all 16 items are summed and averaged to generate a total mean score, with higher scores indicating greater affinity to marianismo beliefs. The wording of the items was adjusted to encompass beliefs about how women overall should behave such that items began with the words “A woman should…” as opposed to “A Latina should…” The MBS has established strong convergent and discriminant validity via positive correlations with measures of cognitive enculturation, self-sacrifice, and interdependence (i.e., familismo; Castillo et al., 2010). It has also demonstrated high reliability within samples of Honduran IPV survivors (α = .822; Sierra, 2020), and adequate to good reliability across subscales within samples of Latina immigrant and non-immigrant women. Specifically, Castillo et al. (2010) have reported the following coefficient alphas for the three scales utilized in the current study: .79 for Virtuous and Chaste, .76 for Subordinate to Other, and .78 for Self-silencing to Maintain Harmony (Castillo et al., 2010). In the present sample, internal consistency alphas were .71, .34, and .72, respectively, with the combined scales demonstrating a consistency of α = .78.

**Post-Traumatic Stress Disorder**
The Brief Posttraumatic Stress Disorder Scale (BPTSD; Campos et al., 2022) is a 5-item self-report scale that screens for symptoms of PTSD and features of C-PTSD—namely, disturbances in self-organization (e.g., negative self-concept). Participants are asked to indicate the degree to which they have been bothered by a series of complaints (e.g., “I have felt distant from other people”) within the last month. Items are rated on a 5-point Likert scale ranging from 1 (never) to 5 (very often). A total severity score (ranging from 0-25) is calculated by adding the scores obtained for each item. The internal reliability of the BPTSD in this study was good (α = .82), and comparable to the coefficient alpha reported by Campos et al. (2022), who found good criterion validity and reliability in a sample of trauma-exposed Chileans (α = .83; see also Langer et al., 2022).

**Depression**

The Patient Health Questionnaire 9 (PHQ-9; Kroenke et al., 2001) is a 9-item self-report depression screening tool based on the 9 DSM-IV depression criteria. Respondents are asked to report the degree to which they have been bothered by a number of depressive symptoms over the last two weeks (e.g., “feeling down, depressed or hopeless”). Each item is rated on a 4-point scale, ranging from 0 (not at all) to 3 (nearly every day). A total symptom severity score (ranging from 0-27) is generated by a sum of scores for the nine items, with a higher score indicating a greater degree of depression symptomatology. The PHQ-9 has proven to be a valid measure of depression within samples of Latinas (Merz et al., 2001; Huang et al., 2006), and has evidenced good reliability among Latina SA survivors (.86 ≤ α ≤ .91; Garibay, 2017; see also Aguerrebere et al., 2021), and SA survivors overall (.81 ≤ α ≤ .89; Carey et al., 2018; see also Dir et al., 2021). In this study, the PHQ-9 evidenced good internal consistency (α = .90).

**Anxiety**
The Generalized Anxiety Disorder 7 (GAD-7; Spitzer et al., 2006) is a 7-item self-report scale and screening tool that assesses the presence and severity of symptoms associated with Generalized Anxiety Disorder. Using a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day) participants are asked to indicate the frequency with which they have experienced each anxiety symptom during the last two weeks. A total severity score (ranging from 0-21) is computed by summing all items, with higher scores indicating greater severity in symptomatology. The GAD-7 has demonstrated construct validity (Spitzer et al., 2006), as well as reliability among Mexican survivors of intimate partner violence (Cronbach’s alpha = .78; Aguerrebere et al., 2021) and SA survivors overall (Cronbach’s alpha = .94; Holder et al., 2023). The internal consistency of the GAD-7 in the current study was excellent (α = .91).

**Sexual Violence Experiences**

The Sexual Experiences Survey, 10-item version (SES; Koss & Gidycz, 1985) is a briefer and modified version of the original SES (SES; Koss & Oros, 1982), a widely used self-report instrument that examines a range of experiences of sexual victimization. The 10-item SES revises the wording of the original scale to align with legal definitions of rape and employs a Yes(1)/No(0) response format. The scale consists of 10 statements describing varying unwanted sexual experiences perpetrated by men (e.g., sex play: kissing, fondling or petting, or sex act) and specific tactics used to coerce the sexual act (e.g., physical force). Participants indicate whether they have ever experienced each of the 10 scenarios. One sample item includes “Have you given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn’t want to because you were overwhelmed by a man's continual arguments and pressure?” Severity of SV was coded as a continuous variable by splitting respondents according to their most severe reported unwanted sexual experience. Based on Davis et al.,’s (2014) guidelines, a severity
ranking scheme was used that combines unwanted sexual outcomes and separates the outcomes by perpetrator tactic. In this way, the respondent was assigned a severity score ranging from 0 (no history of SV) to 10 (completed rape by physical force). Previous studies establish support for the SES’s construct validity and internal reliability among female SV survivors (α = .74; r = .93; Koss & Gidycz, 1985; see also Karabatsos et al., 1997), as well as its reliability among samples of survivors with predominantly Mexican origins (α = .85; Ulibarri et al., 2015). The SES evidenced acceptable internal consistency (Cronbach’s alpha = .64) in this study.

Participants were also instructed to answer six additional questions regarding the sexual violence event that they found the most distressing or upsetting. These questions addressed various aspects of their assault including frequency of victimization, age at the time of the incident, length of time since the assault, perception of life threat, degree of physical injury experienced, and relationship to the perpetrator.

**Disclosure Characteristics**

Respondents were asked to answer “Yes” or “No” to the following question: “Have you ever told anyone about your experience with sexual violence?” Participants who reported having disclosed their experiences answered five questions about their total number of disclosures, sources to whom they had disclosed overall, person/people to whom they first disclosed, and timing and extent of their initial disclosure. They were then administered the Social Reactions Questionnaire Shortened (SRQ-S; Ullman, 2017) to examine invalidating disclosure experiences. The SRQ-S is a 16-item shortened version of the validated Social Reactions Questionnaire (Ullman, 2000), a widely employed measure assessing positive and negative reactions received by sexual assault survivors following disclosure. The SRQ-S is comprised of three primary scales pertaining to three types of disclosure reactions: (1) Turning Against (6 items; e.g., “Told
you that you were irresponsible or not cautious enough”), (2) Unsupportive Acknowledgment (6 items; e.g., “Told you to go on with your life”) and (3) Positive Reactions (4 items; e.g., “Comforted you by telling you it would be all right or by holding you”). Participants are asked to rate the frequency with which they have experienced each of the 16 social reactions from the people to whom they have disclosed their experience, using a 5-point scale ranging from 0 (never) to 4 (always). A mean score for each subscale is computed, such that higher scores on the Turning Against and Unsupportive Acknowledgement subscales represent greater overt and subtle negative reactions, whereas higher scores on the Positive Reactions subscale reflect more positive disclosure reactions. Accordingly, in this study, the Turning Against and Unsupportive Acknowledgement subscales were standardized and combined to form the “Negative Reactions” subscale. The SRQ-S has demonstrated construct and convergent validity, as well as acceptable to excellent internal consistency in survivors of varying ethnic backgrounds and assault experiences (.71 ≤ α ≤ .91; Ullman et al., 2017; see also Ullman, 2000). The internal consistency alphas in this study were as follows: α = .89 for Negative Reactions, and α = .61 for Positive Reactions. Of note, only participants who reported having previously disclosed their unwanted sexual experience were able to fill out the SRQ-S and additional questions on disclosure.

**Self-Invalidation**

In light of the lack of a comprehensive measure in the literature for the assessment of post-assault self-invalidation, a composite measure was generated by standardizing and combining scales that capture two constructs central to self-invalidation: *self-blame* (two scales) and *internalized stigma* (one scale) (Gibson & Leitenberg, 2001; Finkelhor & Browne, 1985). Self-invalidation was thus operationalized via three questionnaires assessing survivors’ assault-related self-blame and internalized stigma (i.e., shame, taintedness, and anticipatory stigma).
Assault-related self-blame was assessed via 9 items from The Blame Attribution Scale (BAS; Meyer & Taylor, 1986) and 10 items from the Trauma Appraisal Questionnaire (TAQ; DePrince et al., 2010). The BAS is a 15-item scale examining causal attributions for sexual violence. It is composed of three subscales: Poor Judgment (5 items), Societal Factors (6 items), and Victim Type (4 items). Only the Poor Judgment (behavioral self-blame) and Victim Type (characterological self-blame) subscales were administered in this study to gauge the degree to which the survivor blames her behaviors, attitudes, abilities, or internal characteristics for her SV experience. Sample items include “I am too trusting” and “I got what I deserved”, respectively. Respondents rate each statement according to the importance of that factor in “helping you explain why this happened to you” on a 5-point Likert-type scale ranging from 1 (not at all) to 5 (completely). Responses are summed for each subscale with higher scores reflecting greater self-blame. The BAS has evidenced convergent validity and high internal consistency in samples of female sexual assault survivors across subscales, with coefficient alphas as follows: .79 for Poor Judgment and .64 for Victim Type (Meyer et al., 1986; see also Arata & Burkhart 1998). Coefficient alphas in this study were $\alpha = .74$ and .59, respectively.

The TAQ is a 54-item validated measure of posttraumatic appraisals with six subscales: Betrayal (7 items), Self-Blame (10 items), Fear (11 items), Alienation (10 items), Anger (9 items), and Shame (7 items). Only the Self-Blame subscale was administered in this study to assess the survivor’s emotional, behavioral, and cognitive components of self-blame experienced at the time of the assault. Participants indicate their level of agreement with a series of thoughts, feelings, or behaviors that they endorsed subsequent to their traumatic event. Sample items include “I felt responsible” and “The event happened because I wasn’t careful enough.” Response options are distributed on a five-point scale, ranging from 1 (strongly disagree) to 5
The scores are summed and averaged to produce an overall self-blame mean score, with higher scores indicating greater self-blame. The convergent, concurrent, and discriminant validity, and reliability of the TAQ has been supported across samples of individuals with diverse ethnicities and trauma experiences (DePrince et al., 2010). Specifically, Babcock & DePrince (2012) reported good internal reliability for the TAQ’s self-blame subscale within a sample of female survivors of intimate partner violence ($\alpha = .89$). The coefficient alpha for this subscale in this study was identical ($\alpha = .89$).

Assault-related internalized stigma was assessed via the Stigma Scale (Gibson & Leitenberg, 2001), an expanded version of the Coffey et al. (1996a) stigma scale. The 9-item measure examines individuals’ experiences of shame, anticipatory stigma, and feelings of innate taintedness concerning a SV incident. Sample items include “How ashamed do you feel about this experience”, “How much do you think others would blame you for what happened?” and “How much do you feel dirtied by this experience,” respectively. Respondents rate each item on a 5-point Likert scale, ranging from 1 (not at all) to 5 (very much), and responses are summed and averaged such that higher scores reflect greater levels of internalized stigma. The Stigma Scale has demonstrated strong validity and reliability in female SA survivors (Cronbach’s alpha = .95; Gibson & Leitenberg, 2001), as well as excellent reliability within samples of low-income rape survivors of predominantly Mexican backgrounds ($\alpha = .94$; Littleton et al., 2008). The coefficient alpha in this study was good ($\alpha = .90$).

Together, the 28 items on these three inventories — BAS- Poor Judgment and Victim Type subscales; TAQ- Self-Blame subscale; Stigma Scale — were averaged to form a 5-point self-invalidation instrument with excellent reliability (Cronbach’s alpha = .91).

**Statistical Analyses**
Independent samples t-tests were conducted to examine group differences between Latina and White survivors across key variables of interest (i.e., PTSD, depression, anxiety, self-invalidation, and marianismo).

For the study’s main hypotheses, a mediation analysis was conducted to investigate the hypothesis that marianismo endorsement mediates the relationship between ethnicity (Latina vs. White) and self-invalidation. Moreover, three multiple hierarchical regression analyses were conducted to examine whether self-invalidation was associated with each negative mental health outcome (i.e., PTSD, depression, anxiety) after accounting for demographic, assault, and disclosure risk factors. All multi-categorical variables were dummy coded before running the main analyses. See Figure 1 for a conceptual model corresponding to the study’s main hypotheses.

Results

Overall Sample Characteristics

Assault-related Characteristics Among Survivors

Table 2 provides a summary of the descriptive data and group differences on assault characteristics for the entire sample and by ethnicity. Almost one-third of the sample (32.6%) reported that their first unwanted experience occurred between the ages of 17 and 20, and for 26.4% it occurred between ages 13 and 16. For a majority of participants (71.3%), the reported SV event(s) had taken place more than three years ago. Overall, the highest level of SV endorsed was a completed rape via verbal pressure, which was reported by 27.1% of the sample. The next most reported SV experience was a completed rape via physical force, which was endorsed by 26.4% of the sample. For more than two-thirds of the sample (68.2%), SV experiences occurred between 2-9 times. Most survivors (72.9%) did not perceive their life to be in danger during the
assault nor did they experience any physical injury (61.2%). The identity of the perpetrator varied across the sample with a majority (23.3%) identifying multiple types of perpetrators, followed by a romantic partner (15.5%), a friend (14.0%), and a stranger (12.4%).

**Disclosure Characteristics Among Survivors**

Table 3 presents a summary of the descriptives and group differences on disclosure characteristics for the entire sample and by ethnicity. A majority (79.1%) of survivors disclosed their assault to someone, with 27 of 129 individuals choosing not to. Of those who did disclose, more than two-thirds (80.4%) disclosed their assault to 1-5 people, and this person’s identity was most frequently identified as a friend (49.0%), followed by a family member (23.5%), and a romantic partner (19.6%). There was more variation regarding the time it took survivors to disclose their assault, with 47.1% disclosing the event more than a year later, 19.6% disclosing months later, and 18.6% choosing to disclose immediately after experiencing it. The extent of detail disclosed was relatively high overall ($M = 3.23, SD = 1.30$). As for the types of disclosure reactions received, the entire sample displayed a low average score for negative reactions ($M = 1.01, SD = 1.00$) and a slightly higher one for positive reactions ($M = 1.84, SD = 0.89$).

Because the number of participants who did not disclose their assault ($n = 27$) constituted more than 20% of the total sample, and to prevent their data from being eliminated from the study’s main analyses, only the disclosure (Y/N) question was included in the analyses that utilized disclosure data. This decision was further justified by the fact that comparisons between Latinas and Whites on all disclosure variables (i.e., assault disclosed, number of disclosures, identity of disclosure source, time since disclosure, extent of disclosure, positive and negative reactions) yielded no significant group differences. There were also no significant differences
between the survivors who disclosed their assault and those who did not disclose across any of the study’s key variables (i.e., PTSD, depression, anxiety, marianismo, self-invalidation).

**Primary Variables**

Initial t-test comparisons between White and Latina respondents on the focal variables of PTSD, depression, anxiety, marianismo and self-invalidation yielded no significant ethnic differences. Therefore, only the descriptive statistics for the entire sample and between Latinas and Whites across these dimensions are presented in Table 4.

**Negative Mental Health Outcomes.** Overall, the total sample presented with a high degree of PTSD, anxiety, and depression symptoms. The average score for PTSD symptoms on the BPTSD scale was 13.77 out of a possible total of 25. Moreover, out of the total sample, 55.0% \((n = 71)\) screened positive for PTSD according to the clinical cutoff of 13.5 for the BTPSD scale (Campos et al., 2022). With regards to depression, the sample’s average symptom severity score on the PHQ-9 was 11.16 out of a total possible score of 27, with 55.8% \((n = 72)\) of survivors meeting the clinical cutoff for depression of 10 or above (Kroenke et al., 2001). Specifically, 14.7% reached the cutoff score for severe depression \((n = 19)\), 16.3% \((n = 21)\) for moderately severe depression, 24.8% \((n = 32)\) for moderate depression, 25.6% \((n = 33)\) for mild depression, and 18.6% \((n = 24)\) for minimal depression. With regards to anxiety, the score on the GAD-7 for the entire sample was 10.09 out of a total of 21, with 55.0% \((n = 71)\) of survivors meeting the clinical cutoff for anxiety of 10 or above (Spitzer et al., 2006). Specifically, 24.0% \((n = 31)\) reached the cutoff for severe anxiety, 31.0% \((n = 40)\) for moderate anxiety, 27.9% \((n = 36)\) for mild anxiety, and 17.1% \((n = 22)\) for minimal anxiety.

**Marianismo.** The mean level of marianismo beliefs for the entire sample was low, with the average MBS score being 1.32 out of 4, indicating that the sample tended to express
disagreement with many of the marianista statements. Specifically, none of the survivors endorsed a level of marianismo beliefs that met the cutoff of 2.5 (Castillo et al., 2010) for an indication of a greater affinity to marianismo. Out of the 16 items of the MBS, the items for which average endorsements were the highest ($M > 1.15$) for the total sample were the following eight statements about women: “should be faithful to her partner” ($M = 3.33$, $SD = 0.71$); “should respect men’s opinions even when she does not agree” ($M = 1.59$, $SD = 0.84$); “should wait until after marriage to have children” ($M = 1.45$, $SD = 0.71$); “should adopt the values taught by her religion” ($M = 1.43$, $SD = 0.65$); “should be pure” ($M = 1.25$, $SD = 0.56$); “should remain a virgin until marriage” ($M = 1.24$, $SD = 0.53$); “should be forgiving in all aspects” ($M = 1.17$, $SD = 0.44$); and “should satisfy her partner’s sexual needs without argument” ($M = 1.16$, $SD = 0.38$).

The means for all other items were under 1.15. With regards to the items that received the lowest average endorsements ($M < 1.05$), the following two statements emerged: “A woman should feel guilty about telling people what she needs” ($M = 1.02$, $SD = 0.12$), and “A woman should do anything a male in the family asks her to do” ($M = 1.04$, $SD = 0.19$).

There were no significant differences between White ($M = 1.35$, $SD = 0.25$) and Latina ($M = 1.29$, $SD = 0.20$) survivors on their mean levels of marianismo, $t(127) = 1.624$, $p = .107$. Further, no ethnic differences were found for survivors’ endorsement of each marianismo domain (i.e., virtuous and chaste, subordinate to others, and self-silencing to maintain harmony). Specifically, Latinas ($M = 1.69$, $SD = 0.42$) did not differ from White survivors ($M = 1.79$, $SD = 0.44$) on their endorsement of items on the Virtuous and Chaste subscale, $t(127) = 1.352$, $p = .179$. Mean differences between Latinas ($M = 1.15$, $SD = 0.23$) and Whites ($M = 1.23$, $SD = 0.25$) on the Subordinate to Others subscale were also not significant, $t(127) = 1.918$, $p = .057$. Lastly,
Whites ($M = 1.08, SD = 0.21$) andLatinas ($M = 1.06, SD = 0.17$) did not differ in their reported 
marianismo beliefs from the Self-Silencing subscale, $t(127) = 0.564, p = .574$.

**Self-Invalidation.** Overall, the total sample demonstrated high levels of self-invalidation. The average self-invalidation score was 2.75 out of 5, and 35.7% of the sample ($n = 46$) reported scores greater than 3, indicating that the sample tended to report a medium level of self-invalidation. Out of the total 28 items in the scale, the specific statements for which the total sample’s overall means were the highest ($M > 3$) include the following ten: “How embarrassed are you about telling people what happened?” ($M = 3.65, SD = 1.37$); “How ashamed do you feel about this experience?” ($M = 3.53, SD = 1.35$); “I am too trusting” ($M = 3.35, SD = 1.24$); “How much do you feel tainted by this experience?” ($M = 3.31, SD = 1.33$); “I was hard on myself about what happened?” ($M = 3.26, SD = 1.42$); “The event happened because I wasn’t careful enough” ($M = 3.12, SD = 1.48$); “I felt guilty” ($M = 3.08, SD = 1.55$); “How concerned are you about how other people would react if they were to find out?” ($M = 3.05, SD = 1.50$); “I should have been more cautious” ($M = 3.03, SD = 1.45$); and “I felt responsible” ($M = 3.02, SD = 1.46$). The means for all other items were under 3. With regards to the items that received the lowest average endorsements ($M < 2$), the following four statements emerged: “I must have done something really awful to make this happen” ($M = 1.95, SD = 1.34$); “I deserved what happened to me” ($M = 1.70, SD = 1.24$); “I was a bad person” ($M = 1.55, SD = 1.08$); and “I got what I deserved” ($M = 1.36, SD = 0.87$). Together, these findings suggest that, overall, survivors’ post-assault self-invalidation is characterized by strong feelings of taintedness, shame, and embarrassment regarding their assault, as well as beliefs that the survivor could have taken measures to prevent her assault (i.e., behavioral self-blame).
Notably, contrary to this study’s first hypothesis, Latina survivors \((M = 2.64, SD = 0.85)\) did not report significantly higher levels of self-invalidation than White survivors \((M = 2.87, SD = 1.02)\), \(t(127)= 1.417, p = .159\). Further, there were also no significant differences between them on their endorsement of the two dimensions (i.e., self-blame and internalized stigma) that are central to self-invalidation. Specifically, Latinas \((M = 2.32, SD = 0.69)\) did not endorse higher levels of self-invalidation on the self-blame subscales compared to White survivors \((M = 2.49, SD = 0.83)\), \(t(127)= 1.289, p = .200\), nor did Latinas \((M = 2.82, SD = 0.99)\) endorse more items on the internalized stigma scale than Whites \((M = 3.02, SD = 1.13)\), \(t(127)= 1.066, p = .288\).

**Correlations**

Correlation coefficients were calculated to assess the interrelationships between variables of interest. Notably, as shown in Table 5, results indicate significant positive correlations between self-invalidation and each of the negative mental health outcomes. Specifically, self-invalidation was positively associated with greater symptoms of PTSD, \(r(127) = .48, p < .001\); depression \(r(127) = .50, p < .001\); and anxiety \(r(127) = .34, p < .001\). *Marianismo* was not significantly correlated with any of these variables, although its positive correlation with self-invalidation was almost significant \(r(127) = .17, p = .062\). Lastly, age was found to be positively associated with higher *marianismo* \((r(127) =.241, p = .006)\).

**Main Analyses**

**Mediation Model**

A mediation analysis was conducted using the Baron and Kenny causal steps approach to test the mediating effect of *marianismo* on the relationship between ethnicity and self-invalidation. The causal variable was ethnicity (reference group White); the outcome variable was self-invalidation, and the mediating variable was *marianismo*. Prior to running the
mediation, separate analyses revealed that out of all the demographics, assault, and disclosure covariates only age, marital status, religious beliefs, SV severity, and SV injury were significantly related to the predictor, mediator and/or the outcome variables. Therefore, the mediation analysis was conducted while controlling for these specific variables.

In Step 1 of the mediation model, the Baron and Kenny approach revealed an insignificant relationship between ethnicity and self-invalidation, $\beta = -0.14, p = .189$. In Step 2, the path between ethnicity and marianismo beliefs was also not significant, $\beta = -0.19, p = .073$. Lastly, in Step 3, the path between marianismo beliefs and self-invalidation was significant $\beta = 0.26, p = .009$. This finding indicates that a greater affinity to marianismo beliefs positively predicted higher self-invalidation, with each unit increase in marianismo predicting a 0.26 increase in self-invalidation. Full details of the results from the Baron and Kenny mediation approach can be found in Table 6 and Figure 2.

Given that the relationship between the predictor ethnicity and the mediator marianismo was not significant, the conditions for establishing an indirect effect were not met and there was no effect to be mediated. Therefore, no support was found for the hypothesized mediation of ethnicity and self-invalidation through the survivor’s marianismo endorsement. However, marianismo did significantly predict greater levels of a survivor’s self-invalidation, whereas ethnicity did not predict either of these relationships.

**Multiple Hierarchical Regressions**

Three separate hierarchical regression analyses were conducted to examine the relationship between predictor variables and each negative mental health outcome (i.e., PTSD, depression, and anxiety). The goal was to examine whether self-invalidation would uniquely contribute to negative mental health outcomes, after controlling for the effects of covariates.
Blocks were ordered such that demographic variables were entered first (i.e., age, SES, education, marital status, religious beliefs); these were followed by assault variables and survivor disclosure (i.e., SV severity, SV frequency, time since SV, age of first SV, perception of life threat, physical injury, perpetrator identity, survivor disclosure Y/N); and then by self-invalidation. Self-invalidation was entered last to test the hypothesis that self-invalidation predicts negative mental health, over and above demographics, assault, and disclosure factors.

**PTSD (BPTSD).** In Model 1, BPTSD scores were regressed on demographic variables and the model was not significant, $R^2 = 0.60$, $F(17, 111) = 0.420$, $p = .978$. Model 2 regressed BPTSD on assault variables and disclosure (Y/N), and was also not significant, $\Delta R^2 = 0.30$, $F(35, 76) = 1.026$, $p = .450$. Notably Model 3, which regressed BPTSD scores on self-invalidation was significant and was thus accepted as the best model. Specifically, adding self-invalidation explained an additional 13% of the variance in BPTSD scores, $\Delta R^2 = 0.13$, $F(1, 75) = 19.760$, $p < .001$. Further examination of Model 3 revealed independent regression coefficients; self-invalidation was the strongest predictor of greater PTSD, $\beta = 0.497$, $p < .001$; followed by perceived life threat, $\beta = 0.382$, $p = .001$, and being single (reference group married or dating), $\beta = 0.245$, $p = .037$, respectively. The overall regression model predicted approximately 50% of the variance in PTSD, $R^2 = 0.50$, $F(53, 75) = 1.387$, $p = .095$.

Together, these findings provide support for the hypothesis that self-invalidation is significantly associated with greater PTSD symptomatology, above and beyond the effects of demographics, assault factors, and assault disclosure. Further, post-assault self-invalidation was the most predictive of greater PTSD symptoms. Other factors that uniquely predicted PTSD symptoms were the perception of life threat during the assault and being single.
Depression (PHQ-9). In Model 1, PHQ-9 scores were regressed on demographic variables. The model was statistically significant, $R^2 = 0.21$, $F(17, 111) = 1.775, p = .040$, and explained 21% of the variance in depression. Within Model 1, having some college experience emerged as the best predictor of higher PHQ-9 scores, $\beta = 0.258, p = .046$, followed by being Catholic, $\beta = -0.239, p = .052$. Model 2 regressed PHQ-9 on assault variables and disclosure (Y/N) and was not significant, $\Delta R^2 = 0.26$, $F(35, 76) = 1.042, p = .429$. However, Model 3, which regressed PHQ-9 on self-invalidation was significant and was accepted as the best model. Specifically, adding self-invalidation explained an additional 9.8% of the variance in PHQ-9 scores, $\Delta R^2 = 0.098$, $F(1, 75) = 16.892, p = < .001$. Further examination of Model 3 revealed that the best predictor of depression was self-invalidation, $\beta = 0.426, p < .001$; followed by rape via verbal pressure (reference group sexual contact via verbal pressure), $\beta = 0.363, p = .042$; current age, $\beta = -0.357, p = .008$; attempted rape via force (reference group sexual contact via verbal pressure), $\beta = 0.305, p = .019$; and having some college experience (reference group graduate degree), $\beta = 0.268, p = .053$, respectively. The overall regression model predicted approximately 57% of the variance in depression, $R^2 = 0.57$, $F(53, 75) = 1.848, p = .007$.

These findings provide support for the hypothesis that self-invalidation is positively associated with greater depression symptoms, over and above the effects of demographics, assault factors, and assault disclosure. Moreover, post-assault self-invalidation was the most predictive of greater depression symptoms. Experiencing an attempted or completed rape through verbal pressure or physical force, being of younger age, and having some college experience also uniquely predicted more depression symptoms.

Anxiety (GAD-7). In Model 1, GAD-7 scores were regressed on demographic variables. This model was statistically significant, $R^2 = 0.28$, $F(17, 111) = 2.543, p = .002$, and explained
28% of the variance in anxiety. Specifically, some college (reference group graduate degree) emerged as the best predictor of higher GAD-7 scores, $\beta = 0.305, p = .014$; followed by being Protestant (reference group atheist), $\beta = -0.253, p = .009$; and age, $\beta = -0.245, p = .026$. Model 2 regressed GAD-7 on assault variables and disclosure (Y/N); this model was not significant, $\Delta R^2 = 0.19, F(35, 76) = 0.786, p = .783$. Model 3, which regressed GAD-7 on self-invalidation was found to be significant and was accepted as the best model. Specifically, adding self-invalidation explained an additional 5.1% of the variance in GAD-7 scores, $\Delta R^2 = 0.051, F(1, 75) = 8.075, p = .006$. Upon further examination of this model’s regression coefficients, multiple predictors were found to be significant. The best predictor of anxiety was rape via force (reference group sexual contact via verbal pressure), $\beta = 0.462, p = .021$; followed by rape via verbal pressure (reference group sexual contact via verbal pressure), $\beta = 0.393, p = .036$; age, $\beta = -0.375, p = .008$; some college (reference group graduate degree), $\beta = 0.347, p = .017$; and self-invalidation, $\beta = 0.309, p = .006$. The overall regression model predicted approximately 52% of the variance in anxiety, $R^2 = 0.52, F(53, 75) = 1.551, p = .040$.

These results support the hypothesis that self-invalidation is positively associated with greater anxiety symptoms, above and beyond the effects of demographics, assault factors, and assault disclosure. Moreover, experiencing rape via physical force is especially predictive of greater anxiety. Experiencing a rape via pressure, being younger, having some college experience, and engaging in self-invalidation also uniquely predict more anxiety symptoms.

**Discussion**

The present study investigated the relations between marianismo, self-invalidation, and negative mental health outcomes in a sample of Latina and non-Latina White survivors of sexual violence (SV). The overarching purpose was to gain a more nuanced and ecological
understanding of the Latina survivor experience by determining whether *marianismo* is a cultural mechanism that can help explain Latinas’ increased risk for self-invalidation and mental illness following SV (Dworkin & Weaver, 2021; Lefley et al., 1993; Moreno, 2007; Nuñez et al., 2016; Pole et al., 2005; Torres, 2017). Overall, the study’s three key findings were the following: (a) self-invalidation was prevalent among Latina and White SV survivors; (b) *marianismo* predicted increased self-invalidation, and (c) self-invalidation, in turn, broadly predicted a variety of detrimental mental health outcomes.

**Latina and White Survivors Evidence Equally High Rates of Self-Invalidation**

Our first aim was to determine whether Latina and White survivors evidenced differential self-invalidation following SV. Contrary to our hypothesis, results revealed that Latina survivors did not report significantly higher rates of self-invalidation than White survivors. In other words, Latina and White survivors were equally likely to blame themselves for their abuse, report assault-related shame, feelings of innate taintedness, and an anticipation of societal stigma. These findings differ from the body of literature that has documented greater post-assault self-blame attributions and victim-blaming attitudes in Latina survivors, compared to Whites (Bryant-Davis et al., 2009; Kellogg & Hoffman, 1995; Lefley et al., 1993; Pole et al., 2005; Wolfe et al., 1994). Instead, in this study, the entire sample reported equally high rates of self-invalidation, with survivors identifying most with statements that reflected their internalization of assault-related stigma, and an attribution of blame for the assault to their actions.

In interpreting any of the current study’s findings that contradict previous research, it is important to bear in mind that the current study was comprised of an international sample from more than twenty countries, whereas a majority of the cited literature on Latinas and *marianismo* has been conducted on ethnic American samples (e.g., Mexican American women). Therefore,
the patterns of findings in this study (e.g., that Latinas and Whites do not differ in self-invalidation) may simply reflect cross-cultural comparisons between Latin American and European women that are naturally different from the domestic differences that exist between American Latinas and American Whites.

Beyond this methodological consideration, another possible explanation for the finding that Latinas and Whites reported similarly high self-invalidation is that rape myths — which are derived from cultural gender role systems and linked with victim-blaming — are prevalent across cultures and have begun to operate implicitly (Dworkin & Weaver, 2021; McMahon & Lawrence, 2011; Suarez & Gadalla, 2010). Recent research suggests that there has been a cultural shift in the kinds of discourses around women and rape that are considered acceptable. Specifically, blatantly sexist victim-blaming attitudes may be declining, but they are being replaced by more subtle or covert rape myths (McMahon & Lawrence, 2011). Some examples include contentions that women indirectly provoke rape, that rape can be accidental, and that non-consent is hard to discern. For example, McMahon & Lawrence (2007) found that although college students did not directly blame the survivor for her assault, they tended to express an understanding that she had deliberately put herself in a bad situation by dressing provocatively, drinking alcohol, or flirting with the perpetrator. Therefore, in alignment with ecological models of SV (Neville & Heppner, 1999), if covert rape myths are being increasingly espoused, it is possible that a Latina or White survivor’s belief in these damaging messages is triggering and amplifying self-invalidating beliefs that they could have prevented, resisted, or foreseen their assault, or that the perpetrator is not fully accountable (Finkelhor & Browne, 1985). Ultimately, these findings add to the literature on the intersection between culture and SV by suggesting that self-invalidating post-assault outcomes are pervasive and cross-cultural, rather than an
experience that uniquely and disproportionately affects Latinas. Survivors’ tendencies to self-invalidate following assault may emanate from their subscription to subtle rape myths that they infer via broader cultural gender norms.

**Marianismo Predicts Greater Self-Invalidation in Latina and White Survivors**

Our second aim was to examine whether marianismo adherence could explain the relationship between the survivor’s ethnicity and her reported levels of self-invalidation. Like our findings for self-invalidation, there were no significant differences between Latinas and Whites in their endorsement of marianismo beliefs. In fact, marianismo adherence was markedly low across the entire sample, with overall endorsements falling between the response options of “Strongly Disagree” to “Disagree.” In other words, Latinas and Whites seemed to agree that traditional marianista statements (Castillo et al., 2010) do not represent the gender value systems they espouse, esteem, or practice. This finding differs from existing research that has documented Latinas’ adherence to marianista beliefs rooted in the duty to self-abnegate, self-sacrifice, and respect patriarchy (Da Silva et al. 2021; Sierra, 2020; Cano, 2003; Moreno, 2007; Murguia, 2001; Torres, 2017), and from research documenting higher endorsement of traditional gender roles among Latinas compared to Whites (Kane, 2000; Williams, 1984).

As mentioned above, one interpretation of these findings is that the international nature of this study’s sample is influencing these non-significant differences. For example, in contrast to the research on marianismo, which has been conducted primarily on American and Mexican American women, the White European women of this sample may be more collectivistic than their White American counterparts. Because collectivism — which overlaps with the Latinx value of familismo — is central to the marianista belief that women should subordinate their
needs to those of the collective (Castillo et al., 2010), it may be that these women’s higher collectivism is accounting for the similar marianismo rates between Whites and Latinas.

Alternatively, as with the literature that suggests that overt forms of victim-blaming are declining (McMahon & Lawrence, 2007), it is possible that marianismo was low in this study because the traditional blatantly sexist marianismo beliefs that were once endorsed at higher levels are now being rejected by newer generations of women. These women’s higher education, greater participation in the workforce, and increased exposure to feminist discourses may be associated with a greater intolerance of sexist gender roles (Gonzales, 1982; Vazquez-Nuttall et al., 1987). Consistent with this speculation, the present sample was highly educated and young (around half of Latinas and half of Whites held a four-year degree or higher and the average age was 28; see Table 1 for more details). This suggests that (a) more highly educated women of younger generations may be less likely to endorse traditional marianista attitudes than those who are older and less educated, and (b) they may perceive marianismo beliefs to be sexist or otherwise antagonistic towards women. In support of this explanation, this study found that greater age was correlated with higher marianismo, which may explain why Latinas, who were significantly younger than Whites (see Table 1), did not report higher marianismo.

Consequently, the marianismo beliefs assessed in this study may either fail to reflect the contemporary egalitarian gender values of young and educated Latinas, or perhaps fail to capture the subtle and more socially acceptable forms of marianismo that persist. For example, women may be unlikely to subscribe to marianista attitudes that emulate hostile sexism (e.g., “A woman should satisfy her partner’s sexual needs without argument”; Castillo et al., 2010). Hostile sexism refers to overtly derogatory attitudes that objectify women, regard them as subordinate and manipulative, and disparage them for deviating from traditional roles (Glick & Fiske, 1996).
However, they may be more likely to endorse *marianista* beliefs that imitate benevolent sexism (e.g., “A woman should be forgiving in all aspects”; Castillo et al., 2010). Benevolent sexism, the subtler and subjectively favorable form of sexism, is characterized by paternalistic attitudes that idealize women’s moral and sexual purity, whilst regarding them as weak and rewarding them for “staying in their place” (Becker, 2010; Expósito et al., 2010; Glick & Fiske, 1996). Echoing this interpretation, studies have reported low *marianismo* among young and educated women (Ruiz-Balsara, 2001; Da Silva et al., 2021), and weak adherence to *marianista* beliefs rooted in overtly sexist edicts of submissiveness and chastity (Cano, 2003; Murguia, 2001).

Importantly, because ethnicity did not significantly predict self-invalidation or *marianismo*, the results from our path analyses did not provide support for the hypothesized mediating effect of *marianismo*. However, given that these non-significant paths approached statistical significance, it is likely that this may have been the artifact of lacking enough statistical power. Nonetheless, perhaps the most remarkable finding of this analysis was that adherence to *marianismo* significantly predicted greater self-invalidation across the sample. Consistent with research suggesting that *marianismo* may facilitate self-blame and shame responses in survivors (Campbell et al., 2009; Da Silva, et al., 2021; Fontes, 2007; Lefley et al. 1993; Moreno, 2007; Perilla et al., 2012), our findings show that endorsing beliefs about a woman’s duty to oblige male desires, embody sexual purity, and subordinate personal needs can place survivors at risk of developing negative self-directed emotions like self-blame, shame, and self-contempt. In other words, Latina and White survivors’ pervasive experiences with self-invalidation may emanate from broader systems of culturally held gender norms that promote victim-blaming and survivor-stigmatizing attitudes.
Ultimately, marianismo may be the Latinx ethnographic manifestation of gender-based SV-supportive norms that have their cultural equivalents in various communities (Dworkin & Weaver, 2021; Suarez & Gadalla, 2010). Although no studies have examined the differences between marianismo and its variants in other cultures, recent research suggests that it may share similar traits with ambivalent sexism (Jezzini, 2013), which comprises both hostile and benevolent sexism. Marianismo and ambivalent sexism both capture an internalization of favorable and unfavorable prescriptions and proscriptions for women and can be conceptualized on a continuum of risk and protective factors (Jezzini, 2013). Consequently, it is possible that the aspects of marianismo that were explored in this study (e.g., self-subordination, self-silencing, and sexual suppression) represent ambivalent female gender role scripts that exist across cultures and are associated with greater self-invalidation in survivors. This speculation is consistent with cross-cultural research that has documented the prevalence of ambivalent sexism in over 19 countries (Expósito et al., 2010; Fiske et al., 2000).

Self-Invalidation Is Among the Strongest Predictors of Survivor Mental Illness

Lastly, our third aim was to assess the unique impact of post-assault self-invalidation on a survivor’s psychological outcomes, after accounting for the effect of demographic factors, the nature of the assault, and whether the survivor disclosed her assault. As expected, our results revealed that self-invalidation uniquely predicted greater PTSD, anxiety, and depression symptoms. Notably, self-invalidation emerged as the single most significant predictor of PTSD and depression symptoms, whilst also being a significant — though weaker — predictor of anxiety symptoms. These results mirror the vast body of research linking self-invalidation to a variety of negative sequelae including PTSD, depression, anxiety, emotional dysregulation, and
Given that over half of our participants met the clinical cutoffs for either PTSD, depression, or anxiety, and that these negative outcomes were strongly predicted by survivors’ high levels of self-invalidation, the link between self-invalidation and mental health merits scholarly attention. It is striking that self-invalidation consistently emerged amongst the strongest predictors of mental illness, surpassing the influence of major risk factors like a survivor’s experience of more severe and/or life-threatening assaults (e.g., rape via physical force). These results provide supporting evidence for the value of employing an ecological framework in the study of women’s experiences following SV by demonstrating that a survivor’s unrelenting self-invalidation may be more damaging to her mental health than the SV incident itself (Neville and Heppner, 1999). The persisting sense of guilt, unworthiness, and defilement that is characteristic in the aftermath of an assault may well be among the strongest risk factors for the development and maintenance of mental illness in survivors.

**Limitations and Future Directions**

Our study bears a number of methodological limitations that merit consideration to guide future empirical work. Beyond the fact that our relatively small sample size ($N = 129$) may have contributed to our non-significant findings, another limitation of our study is its overall lack of generalizability. Although efforts were made to recruit a diverse group of participants, almost 90% of Latina participants were from Mexico, and 86% of White participants were European. Our failure to capture the diverse backgrounds of women who identify as ethnically Latina or White implies that this study’s intended ethnic comparisons may reflect differences between Mexican and European survivors rather than Latinas and Whites. Moreover, as previously...
mentioned, highly educated and young women were overrepresented in the sample, and all participants were recruited via Prolific, a recruitment platform for academic research. The fact that the sample was predominantly young, well-educated, and had a history of participating and receiving exposure to academia may have accounted for the low levels of marianismo that were found. Moreover, it is likely that a survivor’s degree of marianismo is influenced by the generation in which she was raised. Although participants’ ages ranged from 19 to 72 in this study, more than three-quarters were 19 to 30 years old, meaning that the older generations for whom marianismo may be more salient were underrepresented in this sample.

To address these limitations, future research should recruit a larger and more diverse sample that captures a more even distribution of participants’ birthplace, socioeconomic and educational backgrounds, and generation levels. It might be particularly important that these studies examine how generational cohorts vary in their levels of marianismo and self-invalidiation. Such research could help shed light on whether traditional marianismo beliefs are indeed more prevalent among less-educated women and among women from older generations for whom traditional gender ideologies may be more relevant. It may also help discern whether marianismo is more strongly associated with post-assault self-invalidiation and mental illness in nations that are geographically closer (e.g., the United States) to the Latin American countries where marianismo is prevalent. Lastly, because Latinas represent a diverse group of people from a variety of countries, it may also be beneficial to conduct a cross-national study that examines international and domestic differences in self-invalidiation and marianismo among Latinas, and how acculturation can influence these outcomes in Latinas who grow up abroad.

Another limitation concerns our narrow operationalization and assessment of marianismo beliefs. In this study, three subscales from the validated MBS self-report scale (Castillo et al.,
were utilized to tap survivors’ beliefs that women should emulate moral and sexual purity, obey men and patriarchy, and self-abnegate for the sake of interpersonal harmony. These subscales were theorized to hold the greatest implications for how survivors conceptualize the meaning and causal factors of their abuse, and how they respond to their victimization. However, recent research has begun to unearth the importance of addressing the multidimensionality of marianismo (Herrera, 2021), warning against the emphasis on its negative aspects and the enforcement of a cultural deficit perspective. Although some marianismo beliefs can embody rigid gender norms (both hostile and benevolent) that are harmful to women’s well-being (i.e., expectations that women remain virtuous, obey men without question, and subordinate their needs), others can reflect flexible and positive qualities ascribed to women. For example, when applied adaptively, marianismo can celebrate women’s compassion, generosity, spirituality, and collectivism (Amaya & Gray, 2021). Therefore, marianismo beliefs lie on a continuum that encompasses both positive and negative cultural directives (Castillo & Cano, 2008). Given that overtly sexist attitudes may be rejected due to social desirability bias and participants’ younger age and higher education, the marianismo dimensions assessed in this study may have been too blatantly sexist to receive considerable endorsement. Prospective research may possibly find higher adherence to the more positive marianismo dimensions that were not assessed in this study (i.e., women as sources of family unity and spiritual growth; Castillo et al., 2010), and to statements that do not entail any extremes (i.e., overtly benevolent or hostile sexism; Becker, 2010).

Accordingly, it is essential that academia works to expand our understanding of contemporary forms of Latinx traditional gender roles by constructing and validating new marianismo scales in Spanish and English that capture the differences in the valence (benevolent
vs hostile) and application (covert vs overt) of these beliefs. Such an instrument could help accurately reflect current marianista language and detect covert forms of marianismo. Studies may also add to the literature on covert gender norms by assessing women’s marianismo adherence through multimethod approaches (e.g., behavioral observations, reports from loved ones, vignettes, IATs) that elicit their true attitudes about women and sexuality without relying solely on self-reported opinions. Furthermore, given that this study found similar marianismo levels in Latinas and Whites, and that past studies (Fiske et al., 2000; Jezzini, 2013) suggest it may overlap with ambivalent sexism in other countries, research should attempt to ascertain the specific features that render marianismo a culturally specific Latinx gender-value system, distinct from the various ethnographic manifestations of traditional gender roles and sexism that exist in other cultures. Lastly, given the dearth of research on marianismo beliefs in SV survivors, it is critical that studies address the multidimensional nature and adaptive potential of marianismo by identifying which of its values may function as protective and/or risk factors that can mitigate or exacerbate survivors’ self-invalidation and psychological outcomes.

Ultimately, there is a dire need for more academic literature on the lived experiences of Latina SV survivors and the role of cultural values in shaping how they interpret and respond to their assault. To this author’s knowledge, less than five studies have examined marianismo beliefs in survivors of SV or IPV, and most of the existing research on marianismo is limited to dissertations from recent graduates. Given that the marianista values of sacrifice, virtuosity and submissiveness may shape survivors’ self-concepts and appraisals of abuse, it is imperative that academia prioritizes conducting research that assesses the nature and extent of Latina survivors’ self-invalidation, and whether it is reflective of the damaging cultural messages they have come to believe about themselves. Moreover, to this author’s knowledge, this study is the first to
conceptualize survivors’ aggregate experiences of self-blame, shame, taintedness, and anticipatory stigma as a composite experience of post-assault self-invalidation. Because self-invalidation was found to be strongly predictive of survivors’ mental illness, it is crucial that prospective studies address the cumulative and longitudinal impact of these self-devaluating beliefs and emotions, rather than studying each of its constructs in isolation.

**Practical Implications for Clinical Practice and Research**

There are important clinical implications that can be gleaned from this study’s findings. Together, the present findings suggest that self-invalidation is a common post-assault experience that is strongly predictive of mental illness and closely associated with an internalization of traditional female gender roles (i.e., marianismo) in survivors. That a survivor’s feelings of guilt, unworthiness, and defilement are far more damaging to her mental health than the frightening and intrusive experience of SV underscores the need for clinicians to address the emotional trauma that may emerge in the aftermath of an assault and that is compounded by cultural factors that predate it. Assessing for self-blame and shame surrounding victimization may be especially important for treatment planning and identifying survivors at high risk of developing mental illness. It is also critical that trauma-informed interventions target survivors’ pervasive self-invalidation from an understanding that these self-denigrating appraisals may have been internalized and reinforced by their unique ecological settings. Ultimately, treatment should center around the goal of validating the suffering entailed in the survivor’s self-invalidation, gently addressing the invalidating cultural messages that underlie it, and reducing self-invalidating beliefs and emotions that interfere with the client’s goals and values.

Providing culturally responsive care for Latina survivors requires that clinicians be responsive to the gender-based cultural values they espouse, and how these may influence their
self-concepts, the way they make sense of their assault, and what they perceive to be the risks of disclosing it. The present findings demonstrate that marianismo beliefs may contribute to the survivor’s beliefs that she is somehow responsible for her assault and that her victimization is shameful and likely to prompt societal stigma. At the same time, results also suggest that perhaps contemporary expressions of marianismo are more subtle or implicit. The implications of these findings are two-fold. First, it is possible that self-invalidating responses like self-blame are amplified in situations in which the survivor perceives to have violated culturally-valued gender norms that she and/or her support network explicitly espouses. Second, survivors may have inferred and internalized self-invalidating beliefs from cultural norms, without necessarily being aware of them or their origins. Therefore, it is advisable that clinicians pick up on the cognitive distortions that Latinas may endorse as a result of marianismo, and find a balance between (1) communicating a respect for these values, and (2) decreasing the believability of self-invalidating messages (e.g., beliefs in the preventability of the assault or the notion that she has been ruined) that do not serve the client’s personal goals or values.

One approach is to help Latinas make their self-invalidating beliefs explicit by having them articulate them aloud, and evaluating whether believing these thoughts is effective for achieving their goals based on their values. Similarly, clinicians may want to help the client understand whether their marianismo adherence is intrinsic or extrinsic. That is, providers can help survivors recognize the marianismo beliefs they endorse, and whether they endorse them because they are innately valuable to the survivor, or if they do so out of concern for the consequences of not sharing the beliefs of loved ones or community members. Altogether, clinicians can support survivors by facilitating an awareness of the self-invalidating messages the
client has internalized and cultivating opportunities for the development of new self-validating beliefs and self-compassion.

Finally, it is recommendable that future research evaluates whether current interventions for SV survivors need to be culturally adapted to account for the effects of marianismo and self-invalidation on Latinas’ post-assault recovery. Some broad treatment modifications for Latinas that have been identified by prior research include the following: (1) pairing evidence-based treatments (EBTs) with case management; (2) allowing the client to engage in long-winded and non-linear story-telling before identifying targets for exposure; (3) having services be delivered by bilingual Latino providers; and (4) engaging clients via an emphasis on Latinx values like respeto and personalismo, which encourage deference and respect for authority, and a formal yet warm and personal therapeutic alliance (Amaya, & Gray, 2021; Garcia et al., 2022; Low & Organista, 2000). Importantly, evidence suggests that clinicians move beyond providing psychoeducation about typical posttraumatic stress reactions by looking for opportunities to challenge the survivor’s distorted beliefs about SV, such as the assumption that SV is normative to womanhood or that consent is implied in marriage (Garcia et al., 2022). Ultimately, it is imperative that randomized control trials test whether enhanced psychiatric outcomes and retention rates in Latina survivors can be attained by adapting EBTs to incorporate Latinx values whilst also dispelling cultural rape myths that exacerbate self-invalidation.

Conclusion

The present study aimed to obtain a more nuanced and ecological understanding of Latina survivors’ increased risk for post-assault self-invalidation and negative mental health outcomes by determining whether the Latinx gender-based value of marianismo underlies these vulnerabilities. The primary findings were that self-invalidation was elevated among White and
Latina survivors, that marianismo predicted greater self-invalidation, and that self-invalidation, in turn, was associated with poor psychological outcomes (PTSD, anxiety, depression).

Researchers and providers should be mindful that the adverse outcomes of survivors’ self-invalidation may be inextricable from the cultural contexts in which victim-blaming and survivor-stigmatizing attitudes have historically — and perhaps continue— to thrive.
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<td>37.101***</td>
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<tr>
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<tr>
<td>Agnostic</td>
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<td>Atheist</td>
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<tr>
<td>Spiritual</td>
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<td>15</td>
<td>18</td>
<td>14.0</td>
</tr>
<tr>
<td>Protestant</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Other</td>
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<td>0.8</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3.1</td>
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</table>

Note. For variables with expected cell frequencies that were less than 5, Likelihood Ratio test values are displayed. * p < .05., ** p < .01., *** p < .001. * Large ES (Cohen’s d > 0.80 or Cramer’s V > 0.50)
<table>
<thead>
<tr>
<th>Variable</th>
<th>White (n = 63)</th>
<th>Latina (n = 66)</th>
<th>Total (n = 129)</th>
<th>Chi-square value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Violence Severity (SES-10)</td>
<td></td>
<td></td>
<td></td>
<td>15.208</td>
</tr>
<tr>
<td>Other SA</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Sexual contact via verbal pressure</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Sexual contact via misuse of authority</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Sexual contact via physical force</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Attempted rape via intoxication</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Attempted rape via physical force</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Rape via verbal pressure</td>
<td>14</td>
<td>21</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Rape via misuse of authority</td>
<td>0</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Rape via intoxication</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Anal/oral/object penetration via force</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
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<tr>
<td>Rape via physical force</td>
<td>18</td>
<td>16</td>
<td>34</td>
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</tr>
<tr>
<td>Frequency of SA</td>
<td></td>
<td></td>
<td></td>
<td>3.612</td>
</tr>
<tr>
<td>Once</td>
<td>13</td>
<td>9</td>
<td>22</td>
<td></td>
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<tr>
<td>2-9 x</td>
<td>38</td>
<td>50</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>&gt; 10 x</td>
<td>12</td>
<td>7</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Age of First SA</td>
<td></td>
<td></td>
<td></td>
<td>5.941</td>
</tr>
<tr>
<td>1-4 years</td>
<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td>5-8 years</td>
<td>5</td>
<td>13</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>9-12 years</td>
<td>9</td>
<td>8</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>13-16 years</td>
<td>17</td>
<td>17</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>17-20 years</td>
<td>22</td>
<td>20</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>21-24 years</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>&gt; 24 years</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Time Since SA</td>
<td></td>
<td></td>
<td></td>
<td>8.000*</td>
</tr>
<tr>
<td>&lt; 3 months</td>
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<td>4</td>
<td>4</td>
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</tr>
<tr>
<td>3-11 months</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>1-3 years</td>
<td>12</td>
<td>13</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>&gt; 3 years</td>
<td>49</td>
<td>43</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Perception of Life Threat</td>
<td></td>
<td></td>
<td></td>
<td>0.187</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>47</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>19</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Physical Injury</td>
<td></td>
<td></td>
<td></td>
<td>6.406</td>
</tr>
<tr>
<td>No injury</td>
<td>39</td>
<td>40</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Minor injury</td>
<td>15</td>
<td>22</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Worse than bruises</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Requiring medical treatment</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Requiring hospitalization</td>
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<td>0</td>
<td>1</td>
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</tr>
<tr>
<td>Perpetrator ID</td>
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<td></td>
<td></td>
<td>13.645</td>
</tr>
<tr>
<td>Stranger</td>
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<td>6</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Non-romantic acquaintance</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Romantic acquaintance</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>6</td>
<td>12</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Casual or first date</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Romantic partner</td>
<td>5</td>
<td>15</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Multiple types of perpetrators</td>
<td>17</td>
<td>13</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Note. For variables with expected cell frequencies that were less than 5, Likelihood Ratio test values are displayed. * p < .05.

Large ES (Cohen’s $d > 0.80$ or Cramer’s $V > 0.50$)
### Table 3

Descriptive Statistics and Group Differences for Disclosure Variables Between White and Latina Survivors

<table>
<thead>
<tr>
<th>Variable</th>
<th>White (n = 63)</th>
<th>Latina (n = 66)</th>
<th>Total (n = 129)</th>
<th>Chi-Square/ ( t )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SV Disclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>13</td>
<td>27</td>
<td>20.9</td>
</tr>
<tr>
<td>Yes</td>
<td>49</td>
<td>53</td>
<td>102</td>
<td>79.1</td>
</tr>
<tr>
<td>Number of Disclosures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 people</td>
<td>36</td>
<td>46</td>
<td>82</td>
<td>80.4</td>
</tr>
<tr>
<td>6-10 people</td>
<td>9</td>
<td>5</td>
<td>14</td>
<td>13.7</td>
</tr>
<tr>
<td>11-15 people</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2.9</td>
</tr>
<tr>
<td>16-20 people</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>&gt; 20 people</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Identity of Disclosure Source</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>49.0</td>
</tr>
<tr>
<td>Family</td>
<td>13</td>
<td>11</td>
<td>24</td>
<td>23.5</td>
</tr>
<tr>
<td>Romantic Partner</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>19.6</td>
</tr>
<tr>
<td>Therapist</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>5.9</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>Time Since Disclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediately after</td>
<td>12</td>
<td>7</td>
<td>19</td>
<td>18.6</td>
</tr>
<tr>
<td>Week after</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>10.8</td>
</tr>
<tr>
<td>Month after</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3.9</td>
</tr>
<tr>
<td>Several months after</td>
<td>8</td>
<td>12</td>
<td>20</td>
<td>19.6</td>
</tr>
<tr>
<td>&gt;1 year after</td>
<td>21</td>
<td>27</td>
<td>48</td>
<td>47.1</td>
</tr>
<tr>
<td>Extent of Disclosure</td>
<td>3.29</td>
<td>3.17</td>
<td>3.23</td>
<td>1.30</td>
</tr>
<tr>
<td>Positive Reactions (SRQ-S)</td>
<td>1.73</td>
<td>1.95</td>
<td>1.84</td>
<td>0.89</td>
</tr>
<tr>
<td>Negative Reactions (SRQ-S)</td>
<td>1.03</td>
<td>1.00</td>
<td>1.01</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Note.* For variables with expected cell frequencies that were less than 5, Likelihood Ratio test values are displayed. *p < .05.*
### Table 4

Descriptive Statistics for Focal Post-Assault Predictors, Mediators and Outcome Variables Between White and Latina Survivors

<table>
<thead>
<tr>
<th>Variable</th>
<th>White (n = 63)</th>
<th>Latina (n = 66)</th>
<th>Total (n = 129)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>PTSD (BPTSD)</td>
<td>13.60</td>
<td>5.06</td>
<td>13.92</td>
</tr>
<tr>
<td>Depression (PHQ-9)</td>
<td>11.81</td>
<td>6.71</td>
<td>10.55</td>
</tr>
<tr>
<td>Anxiety (GAD-7)</td>
<td>10.41</td>
<td>5.29</td>
<td>9.77</td>
</tr>
<tr>
<td>Marianismo Endorsement (MBS)</td>
<td>1.35</td>
<td>.25</td>
<td>1.29</td>
</tr>
<tr>
<td>Self-Invalidation</td>
<td>2.87</td>
<td>1.02</td>
<td>2.64</td>
</tr>
</tbody>
</table>

*Note.* Mean differences for these variables were not statistically significant.
### Table 5

*Correlations Between Marianismo Beliefs, Self-Invalidation and Negative Mental Health Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pearson Correlation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>1. Marianismo (MBS)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>129</td>
<td>.036</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.686</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. PTSD (BPTSD)</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>129</td>
<td>.513**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Depression (PHQ-9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>129</td>
<td>.129</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Anxiety (GAD-7)</td>
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<td>.403**</td>
<td>.737**</td>
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<td>Sig. (2-tailed)</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
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<td>5. Self-Invalidation</td>
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<tr>
<td></td>
<td>129</td>
<td>.481**</td>
<td>.495**</td>
<td>.339**</td>
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</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
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</table>

*Note. ** p < .001.*
Table 6

*Baron and Kenny Approach for Mediation of Ethnicity on Self-invalidation Through Marianismo*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$R^2$</th>
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</thead>
<tbody>
<tr>
<td>Model 1</td>
<td></td>
<td></td>
<td></td>
<td>0.27*</td>
</tr>
<tr>
<td>(Intercept)</td>
<td>3.03</td>
<td>0.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity (Latina)</td>
<td>-0.36</td>
<td>0.20</td>
<td>-0.19</td>
<td></td>
</tr>
<tr>
<td>Model 2</td>
<td></td>
<td></td>
<td></td>
<td>0.30*</td>
</tr>
<tr>
<td>(Intercept)</td>
<td>1.19</td>
<td>0.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity (Latina)</td>
<td>-0.09</td>
<td>0.05</td>
<td>-0.19</td>
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<tr>
<td>Model 3</td>
<td></td>
<td></td>
<td></td>
<td>0.32**</td>
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<tr>
<td>(Intercept)</td>
<td>1.74</td>
<td>0.64</td>
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<tr>
<td>Marianismo</td>
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<td>0.20</td>
<td>-0.14</td>
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<td></td>
<td>1.08</td>
<td>0.40</td>
<td>0.26**</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The following variables were controlled for in each model: age, marital status, religious beliefs, sexual violence severity and assault injury. For the predictor Ethnicity, the reference category was White. * $p < .05$; ** $p < .01$. 
Figure 1

*Conceptual Model for Main Analyses*

![Conceptual Model](image)

*Note.* Mediation effect of ethnicity on S-Inv through marianismo (left). Hierarchical multiple regression examining the unique contribution of S-Inv to negative MH outcomes (right).
Figure 2

Mediation Analysis

\[ \beta = -0.19 \quad p = 0.073 \]

\[ \beta = 0.26^{**} \quad p = 0.009 \]

\[ \beta = -0.14 \quad p = 0.189 \]

Note. Mediation of ethnicity on S-Inv through marianismo using standardized regression coefficients. Analyses controlled for the significant covariates of age, marital status, religion, SV severity and SV injury. **p < .01