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### Sustenance Abuse: Anorexia, Bulimia, and & Black Women

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Olivia J. Williams

### Sustenance Abuse: Anorexia, Bulimia, & Black Women

“Food had become my drug.” Thus writes Stephanie Covington Armstrong, a bulimia survivor—and black woman. Contrary to popular belief, eating disorders are not limited to wealthy white women trying desperately to achieve a bone-thin summer body. In fact the National Eating Disorder Association (NEDA) reports that black women are actually 50% more likely than white women to show signs of bulimia (“Statistics & Research on Eating Disorders”). But black eating disorder patients are often undiagnosed and under researched. Many black women have attested that their symptoms were not taken seriously by medical professionals, and even official research papers and medical reports claim a low prevalence of disordered eating among black women. However, black women are indeed suffering from disordered eating. The question is why? Despite common perceived correlations between eating disorders and body image, eating disorders among black women have more to do with self-harm and unhealthy coping mechanisms.

Despite the medical community’s flawed assessment, black women extensively suffer from eating disorders. In a 2007 University of Michigan medical study, researchers reported that “the prevalence of most eating disorders among Blacks is uncommon” (Taylor et al., S13). Taylor et al. argue that eating disorders are largely uncommon among African Americans but should still be taken seriously: “cultural differences must be considered when diagnosing eating disorders in Black populations” (S13). The evaluation that eating disorders among blacks is uncommon, however, should be taken with a grain of salt—medical professionals have been known to dismiss black people’s, and particularly black women’s, symptoms (Anwar). Black eating disorder survivor Erica Hawkins recounts in a *HuffPost* article that “doctors in [her] own

life failed to notice the signs of [her] anorexia” (“Anorexia and Bulimia”). She states that when she was hospitalized once for symptoms related to her anorexia (dehydration and kidney infection), doctors commented on her dramatic weight loss, but didn’t associate it with an eating disorder. Later, she says, she was prescribed Adderall for her ADHD, and abused the medication in conjunction with her starving rituals. The prescribing doctor noted her 15-pound weight loss since her last checkup, Hawkins replied that the weight loss was intentional, and the doctor “never brought it up again” (“Anorexia and Bulimia”). Stephanie Covington Armstrong said in an interview with *Slate* that when she decided to sign up for a bulimia research study as an attempt to seek recovery, “the doctors looked confused” and “told her that she was the first African-American applicant in the program” (Konstantinovsky). The experience angered Armstrong and triggered feelings of loneliness: “people aren’t used to women of color coming forward with problems or issues” she says (Konstantinovsky)—it’s unclear whether this is due to unawareness on the part of the medical professionals or attempts at symptom suppression on the part of black women.

Even beyond Armstrong’s and Hawkins’ experiences, statistical proof shows that medical professionals discriminate against black women’s symptoms. Referring to a 2006 study by Gordon KH et al., the NEDA reports that when shown eating disorder symptoms, 44% of clinicians “identified the white woman’s behavior as problematic,” while only 17% said the same for a black woman with identical symptoms (“Statistics & Research on Eating Disorders”). The NEDA argues that historical bias in favor of white women leads to gaps in research about women of color. While the NEDA does acknowledge that women of color often don’t report their symptoms, the organization asserts that healthcare providers often under or misdiagnose

women of color and that there is inherent cultural bias within the metric used for diagnosing eating disorders (“Eating Disorders in Women of Color”).

Armstrong and Hawkins respectively met the diagnostic criteria for bulimia and anorexia outlined by the Diagnostic and Statistical Manual of Mental Disorders. The criteria for an anorexia diagnosis is a “body weight less than 85% of that expected” for an individual, an “intense fear of gaining weight” despite being critically underweight, and the “undue influence” of weight or body shape on self-evaluation (The British Psychological Society, appendix 17). For bulimia, symptoms are “recurrent episodes of binge-eating” (consumption of food portions larger than most people would eat within a set amount of time steeped in a “sense of lack of control...during the episode”), regular detrimental actions to combat weight gain (“self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise”), and “self-evaluation...unduly influenced by body shape and weight” (The British Psychological Society, appendix 17). Yet despite exhibiting most or all of these symptoms, neither Hawkins nor Armstrong received proper care for their disorders until they assertively sought it out themselves. Although the NEDA doesn’t detail the specific cultural bias within diagnostic measures for eating disorders, clearly some underlying prejudice is keeping black women from receiving diagnoses.

To gain additional information on black women’s body image, eating habits, and encounters with eating disorders, I conducted an informal online survey here at Washington University. Out of 57 black woman respondents, only 5 (~9%) had ever been diagnosed with an eating disorder (Figure 1.1). Conversely, out of six respondents who admitted to using food as a punishment “often”—i.e. bingeing, intentionally skipping meals, or restricting food amounts (Figure 1.2)—only two had been diagnosed with an eating disorder. Here, while on a smaller

scale, is another example of the disparity between symptoms mentioned in the criteria for bulimia diagnosis by The British Psychological Society (appendix 17) and exhibited by black women, and proper diagnosis by the medical community.

### Have you ever been diagnosed with an eating disorder?

57 responses

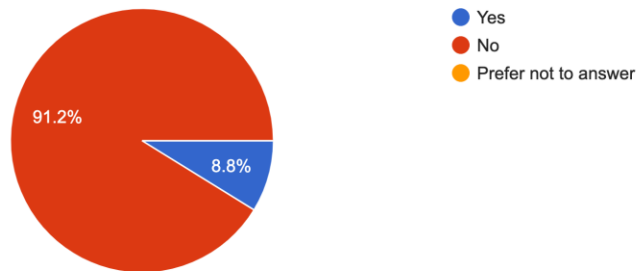


Figure 1.1

### How often do you use food as a punishment? (i.e. skipping meals, bingeing, restricting food amounts)

57 responses

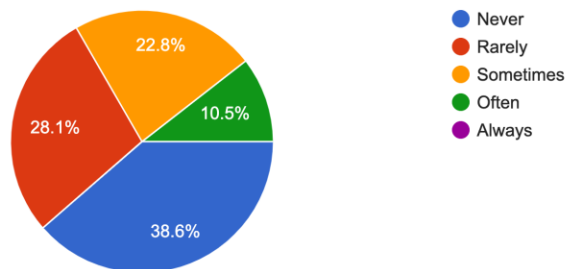


Figure 1.2

Out of 90 total survey respondents (inclusive of all races & gender identities), more than half (~57%) knew black women who practiced unhealthy, bulimia-like eating habits such as skipping meals or purging (Figure 1.3). However, only 20% of respondents had ever known a black woman who was diagnosed with an eating disorder (Figure 1.4). Conversely, approximately 86% of respondents knew a non-black person who practiced unhealthy eating

habits or was diagnosed with an eating disorder (Figure 1.5); however, I partially attribute this large disparity to the combined wording of the question. (The “unhealthy eating habits” and “eating disorder diagnosis” were two separate questions in relation to black women, while for non-black people these distinctions were combined. In a future survey I would keep these distinctions separate for both racial groups so that the numbers could be more accurate.) Despite the flaw in my question formatting, disordered eating among black women is obviously faced with imbalanced perceptions.

Have you ever known a black woman who practiced unhealthy eating habits? (i.e. skipping meals, purging, etc.)

90 responses

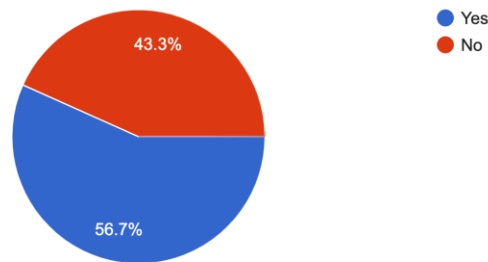


Figure 1.3

Have you ever known a black woman who was diagnosed with an eating disorder?

90 responses

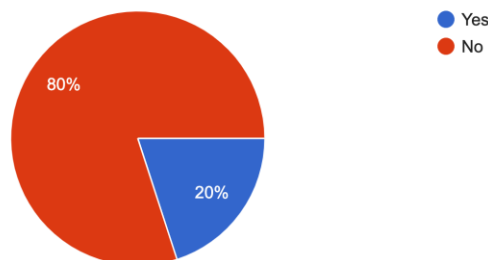


Figure 1.4

Have you ever known a non-black person who practiced unhealthy eating habits and/or was diagnosed with an eating disorder?

90 responses

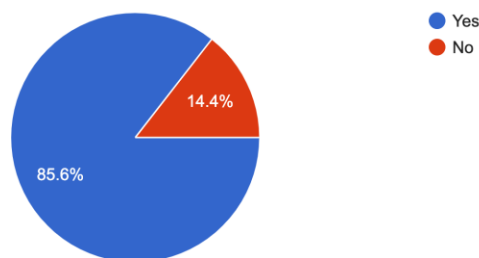


Figure 1.5

In common thought, eating disorders are often linked with a desire for a body that meets standards set by popular media—overly skinny, “model-esque” body types. Often this desire is taken to a dangerous and life-threatening state. Of course, this link is a simplification—much more goes into an eating disorder beyond skewed body ideals. However, black women often don’t have a desire for this overly-skinny body type. In “Beauty and Body Image Concerns,” Germiné H. Awad et al. argue that black women’s body image is complex and largely shaped by environment—in the black community, black women are usually, as one research participant worded it, “pushed to be thicker” (547). Black female focus group participants saw a dissonance between the ideal curvy body type promoted in black communities and the thin body idealized by white communities. The participants found it difficult to thrive in predominantly white schools and felt out of place in corporate spaces where Eurocentric metrics for appearance were prioritized (547). The NEDA supports Awad et al.’s observation that black women in white environments often find themselves leaning out of the curvy body ideal and toward Eurocentric body standards, calling this phenomenon “acculturation” (“Statistics & Research on Eating Disorders”). In “Weight-Gain Misperceptions and the Third-Person Effect in Black and White College-bound Females,” Webb et al. report that black female first-year college students hold a

“curvaceous yet thin ideal” (247). Their research establishes that both white women and minorities have a desire to lose weight upon entering college, but, in agreement with Awad et al.’s conclusions, black women are attempting to achieve a slim-thick body style, rather than a skinny or thin body shape.

In my informal online survey, I asked black women respondents how satisfied they were with the current states of their bodies on a scale of 1-10 (with 1 representing “completely dissatisfied, hate it” and 10 representing “perfectly happy, love it”). Most black women (~44%) marked their satisfaction as either a 7 or 8 (Figure 2.1), indicating a rather high body confidence. However many women (~30%) marked a satisfaction level below 5. This data illuminates responses to the question about how often respondents thought about losing weight on a scale of 1-5 (with 1 representing “rarely/never” and 5 representing “every day, several times a day”). Most women (~49%) selected either a 4 or 5 (Figure 2.2), suggesting a frequent desire for weight loss. However, most respondents aren’t longing for a skinny, petite body: almost 60% said their ideal body shape is “slim-thick” (Figure 2.3), which has been defined as similar to the figures of Michelle Obama or Jennifer Hudson (Webb et al.). This data on body image supports Webb et al.’s aforementioned findings on the body ideals of black female college students, as well as comments from eating disorder clinician Gayle Brooks in an interview with *Slate*: “Within the African-American culture, they may be more vulnerable to bulimia and binge eating because there may still be some protective measures around the beauty ideal not being so pencil thin. However, conflicts around body image and using food to manage emotions—you’re going to see that in women of color” (Konstantinovsky). Brooks affirms that the curvier body ideal common in black culture still allows for bulimia-like symptoms mentioned in my survey (fasting,



bingeing, etc.), which are more concerned with preventing weight gain (The British Psychological Society 17) than achieving a pencil thin look.

Of the five survey respondents who had been diagnosed with an eating disorder, two had an ideal body shape of skinny, two an ideal of curvy, and one of lean or muscled. Their satisfaction with the current state of their bodies also varied widely, ranging from 2-7 with no two respondents giving the same answer. Obviously, body image holds less statistical weight (no pun intended) when it comes to black women and eating disorders.

**On a scale of 1-10, how satisfied are you with the current state of your body? (i.e. weight, shape, etc.)**

57 responses

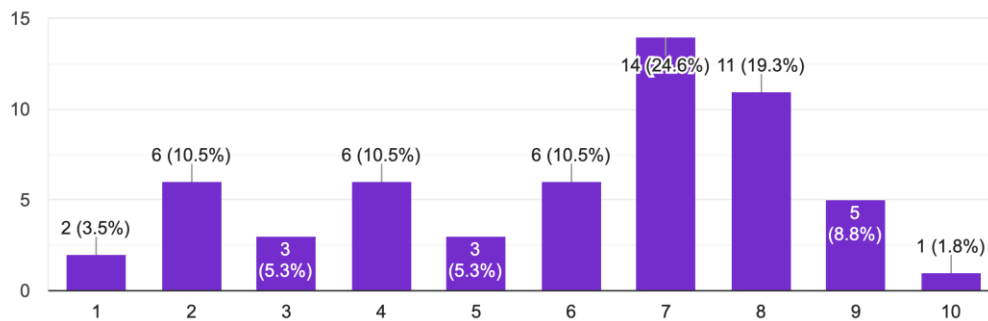


Figure 2.1

**On a scale from 1-5, how often do you think about losing weight?**

57 responses

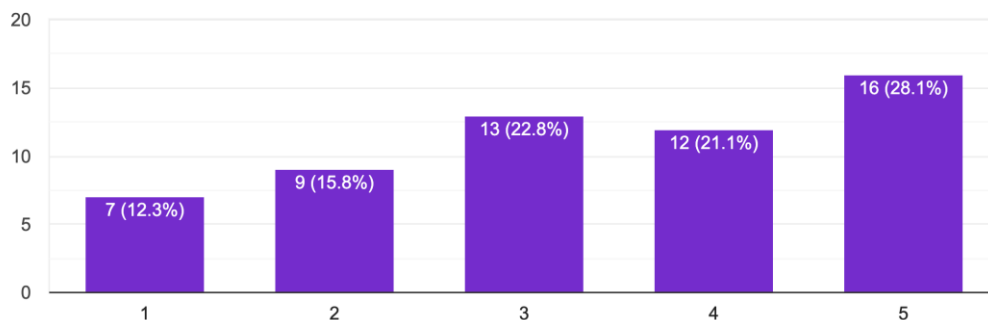


Figure 2.2

### What is your ideal body shape closest to?

57 responses

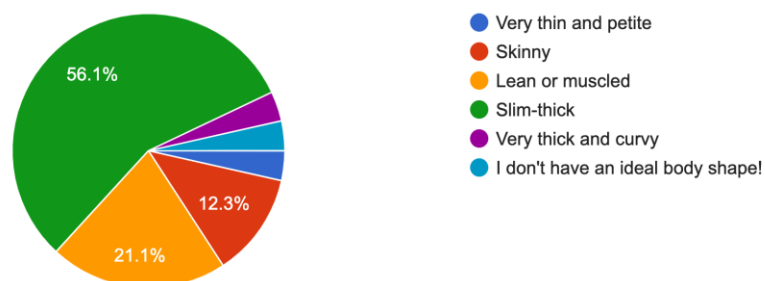


Figure 2.3

There are some exceptions to black women’s countercultural body positive outlook—namely, the pressure of being held to traditional Eurocentric body standards in predominantly white spaces. One black female respondent in Awad et al.’s paper said that students at a predominantly white high school she used to visit would comment negatively on her body: “ewww she’s so disgusting she needs to lose some weight” (547). However, the respondent’s permanent inhabitation of a predominantly black neighborhood and school kept her from desiring to conform to these standards (547). Another respondent regularly attended a white high school, and admitted the environment affected her body image: “... everyone were [sic] like really skinny and tall. I used to like always work out and barely eat so I could lose weight” (547). Other respondents felt that conforming to white body standards led to higher chances of success in the corporate world: “it’s not even professional to be like super shapely, like in a suit you know. So it’s not professional to be Black” (547). Erica Hawkins was also affected by her predominantly white environment, citing the “envy [she] had for the slim physiques of the girls in [her] mostly white cheerleading squad” as one of many pressures that pushed her toward an eating disorder (“Anorexia And Bulimia”). However, pressure to conform to white body norms appears to be the

exception, not the rule. Awad et al. conclude that “items about weight [are] less applicable to Black women” (547)—and, based on the previously recounted evidence, body image as a whole doesn’t serve as the primary reason for eating disorders among black women.

If black women’s ideal body image tips more toward a curvy figure (except for moments in predominantly white environments), why are black women experiencing disordered eating? For Armstrong, bingeing and purging were ways to cope with stresses from food insecurity and sexual abuse: “My Eating Disorder has been affected as much by the stressors of not knowing when or how I would eat as my sexual abuse” (“Trauma Affects Your Relationship”). In the arena of food insecurity, Armstrong isn’t alone: the NEDA reports that “teenage girls from low-income families are 153% more likely to be bulimic than girls from wealthy families” (“Statistics & Research on Eating Disorders”). Armstrong’s experience as a food insecure child added to the guilt she felt with her bulimia: “I felt conflicted when my mother could actually afford to feed me and I refused to eat; there were equal measures of guilt and shame mixed with smug self-satisfaction” (Stovall). Sudden exposure to large amounts of food was also negative for Armstrong, who was used to limited food accessibility: the abundantly accessible food at her cheerleading camp only served as the binge part of her binge-and-purge cycle (Stovall).

Plummeting self-esteem due to sexual abuse also pushed Armstrong towards the abusive acts of bulimia. After being raped at the age of twelve, Armstrong says, “I started thinking that something was wrong with me...that I wasn’t lovable...and that I was damaged...So the way that I was able to kind of calm those fears was with food...I just always wanted to have some control around my food” (Williams et al.). Writing for *The New York Times*, Armstrong adds, “I used food to suffocate my uncomfortable feelings. Food had become my drug” (“When to Quit Dieting”). Anorexia also served as an abusive coping mechanism for Hawkins as she struggled

with mental illness and low self-esteem. Hawkins describes a “need to control stress by hurting my body...I didn’t know how to deal with stress, but I did know how to deal with my appearance” (“Anorexia And Bulimia”).

Both women’s burdens were increased by the stigma within the black community. In an interview with BBC, Armstrong discussed the stifling feeling of suffering through an eating disorder within a community that usually doesn’t address mental illnesses and other complex, beyond-physical problems: “It’s all about the secrets in our community. You do not admit that you’re in crisis” (“Challenging the Stereotype”). “I was told that African-Americans don’t have eating disorders,” Armstrong related in another interview with *theGrio*, “and I had family members and friends who would say to me ‘just go to church’ or ‘just don’t talk about it’” (Williams et al.).

Hawkins’ black community played a more overtly negative role in her anorexia experience: she endured teasing about her appearance from her family before her eating disorder began, then when her anorexia had taken its toll over several years, her parents noticed her “gaunt and unhealthy” appearance and “gave [her] an ultimatum: If [she] didn’t stop what [she] was doing, [she] wouldn’t get to leave for college in the fall” (“Anorexia and Bulimia”). For Hawkins, “there was never talk of treatment except as a punishment” (“Anorexia and Bulimia”). She attributes her parents’ stern response to the priority of survival in the black community: in the struggle to provide financial and physical care for their children in a racist society, black people often “regard certain problems [such as mental illness and eating disorders] as just not real or significant enough” (“Anorexia and Bulimia”). This deemphasizing by Hawkins black community could also account, in part, for Armstrong’s ordeals: lack of true understanding of

what Armstrong was suffering may have led her community to resort to platitudes and denial of an actual medical issue.

The NEDA has suggested additional causes for eating disorders among women of color: as members of “multiple subordinate groups” (within the discriminatory social structures in the U.S.), women of color “face substantially more stress”—therefore, “eating disorders in women of color may be, in part, a response to environmental stress (i.e. abuse, racism, poverty)” (“People of Color and Eating Disorders”). These statements line up with Armstrong’s and Hawkins’ experiences with abuse, poverty, and erasure by the medical community based on their race.

Clearly, eating disorders are more prevalent among the black community than people may believe. Based on Hawkins’ and Armstrong’s personal testimonies, as well as previously mentioned research, eating disorders are less about appealing to a skinny body image for black women (especially considering the prevalence of bulimia), and more about negative, self-harming coping mechanisms. There’s been little research on the true causes of eating disorders among black women, and even less on how to raise awareness for the issue. The NEDA maintains that the flaw within the medical system must be addressed: professionals need to begin accounting for cultural effects on women of color and their experience as an oppressed group (“Eating Disorders in Women of Color”). What would this look like? For a start, medical professionals could start taking into account experiences like Armstrong’s and Hawkins’, where pressure and stigma within the black community compelled them to hide their disorders and lie about their condition to medical professionals. Medical professionals could realize the myriad systemic oppressions working against black women: the erasure due to racism and misogyny that causes them to bottle up emotional responses to abuse and poverty. Most importantly, medical

professionals need to *listen*—set aside the “strong black woman” archetype and other assumptions on what black women are supposed to be, and simply take black women’s stories at face value—just like medical professionals do with white women. Ultimately, ending this disparity will not only save lives and bodies, but will also begin to forge a long overdue path to equality within the medical arena.

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