

## ABSTRACT

Title: UNDERSTANDING BULIMIA: A  
QUALITATIVE EXPLORATION OF THE  
ROLES OF RACE, CULTURE, AND FAMILY

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The eating disorder, bulimia nervosa, is a serious physical and mental illness destroying the lives of millions of men, women, and their families. It is characterized by recurrent binge eating and compensatory behaviors (e.g., self-induced vomiting), and afflicts 1-5% of the general U.S. population. Unlike other eating disorders that appear to affect specific racial groups, bulimia more equally affects people of all races. Yet, very little attention has been given to learning about the ways in which women from diverse racial/cultural backgrounds experience bulimia. Thus, the present qualitative study explored the question: How do young African American, Latina, and Caucasian women describe their experiences with bulimia within their racial, cultural, and familial contexts? Open-ended, in-person interviews were conducted with 33 young adult women (ages 18-30) who self-identified as African American, Latina, or Caucasian and who experienced bulimia while living with a parent. Questions were based on sensitizing concepts taken from feminist and family systems theories, and encouraged women to explore their perceptions of how their racial, cultural, and familial contexts influenced their experiences with bulimia. A modified grounded theory approach was used to interpret the data, and findings were organized at sociocultural, familial, and individual levels. Common experiences for many

of the women, regardless of race, included sociocultural pressure to be thin; unhealthy family environments that included poor communication, strained relationships, and emphasis on members' appearances; and individual management of comorbid psychological disorders and emotions. Unique processes related to African American women's and Latinas' experiences with bulimia included living in a bicultural context with cultural and familial stigmas surrounding mental health. Additionally, African American women reported overall healthier family environments, in which they had supportive relationships and more open communication. Based on these findings, the theoretical framework was enhanced with race- and culture-specific models. Implications for research related to diverse families' experiences with eating disorders, policies designed to help people of all backgrounds affected by eating disorders, as well as the development of culturally sensitive therapy interventions for families affected by bulimia are discussed.

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ROLES OF RACE, CULTURE, AND FAMILY

By

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## CHAPTER 1: INTRODUCTION

Eating disorders, such as anorexia and bulimia, are serious illnesses that destroy the lives of millions of men and women and their families of all racial and socioeconomic backgrounds. It is well-documented that people from as many as 40 countries are struggling with eating disorders, and just in the United States alone at least 2-4% of the general population is fighting a life and death battle with a diagnosable eating disorder, and up to 25% of young adult women are suffering from sub-clinical eating disorder symptoms (Maine, 2006; NEDA, 2002). Symptoms of eating disorders, such as self-induced starvation, violent purging of food, and excessive overeating, can wreak havoc on one's physical health. Likely complications of these illnesses include, but are certainly not limited to, heart attack, abdominal distress, anemia, kidney failure, irreversible osteoporosis, electrolyte imbalances, esophageal tears, stomach ruptures, high blood pressure, high cholesterol, Type II diabetes, and gallbladder disease (NEDA, 2002). Additionally, people with eating disorders tend to simultaneously experience other mental disorders, such as depression, anxiety, drug and alcohol addictions, and post-traumatic stress from previous trauma (e.g., childhood sexual abuse) (NEDA, 2002). If left untreated, people have a 20% chance of dying from an eating disorder, which is a mortality rate twelve times higher than all other mental illnesses, thus classifying eating disorders as the deadliest mental disorder (Schooler, Ward, Merriwether, & Caruthers, 2004; Walcott, Pratt, & Patel, 2003).

A growing body of research has explored the differences in eating disorders among women from various racial and cultural backgrounds. However, a heavy emphasis has been on comparing African American women to Caucasian women, with few studies

including Latinas, and less than a handful of studies incorporating Asian American, Native American, and racial minority male populations (Zhang & Snowden, 1999). Thus far, the research on racial differences in eating disorders suggests that Caucasian and Latina women tend to seek a thinner body shape than African American women and engage in efforts to try to lose weight at twice the rate of African American women, regardless of their actual body weights and sizes (Marx 2000; Petersons, Rojhani, & Steinhaus, 2000; Sorbara & Geliebter, 2002). It is believed that Caucasian and Latina women have more willingly adopted the Western standard of beauty that “thin is in” than have African American women, who are more likely to temper the dominant culture’s beliefs about body weight with their racial culture which values more voluptuous and curvier female bodies (Petersons et al., 2000; Striegel-Moore, Schreiber, et al., 2000; Walcott et al., 2003). As a result of this difference in attitudes about bodies, Caucasian and Latina women are more likely to suffer from anorexia nervosa than African American women, excessive overeating is the most likely to develop in African Americans, and all three groups may be equally likely to struggle with bulimia nervosa (Schooler et al., 2004; Sorbara & Geliebter, 2002; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000). Thus, since research has shown that bulimia is likely to affect women from diverse backgrounds at fairly equal levels, the present study sought to understand if and how women’s experiences with the same illness may be different based on their racial and cultural backgrounds.

Over the past 30 years, research on eating disorders in families has implicated the role of familial influences in women’s experiences with eating disorders. Destructive communication patterns, high levels of conflict, divergent perceptions of the parent-child

relationship, and a heavy emphasis on family members' physical appearances have been shown to be distinguishing factors between families with and without eating disorders (Cachelin, Weiss, & Garbanati, 2003; Johnson & Flach, 1985; McDermott, Batik, Roberts, & Gibbon, 2002; Waller & Hartley, 1994). Additionally, the circumplex model (Olson, Russell, & Sprenkle, 1989), an outgrowth of family systems theory, has been widely used to investigate families affected by eating disorders. The three primary constructs of this model include families' abilities to accommodate change, maintain a healthy level of closeness in relationships, and effectively communicate with each other. From this research, certain constellations of family interaction patterns seem to be related to the type of eating disorder a person develops. For example, families affected by anorexia are often characterized by enmeshed family boundaries (overly cohesive) and an avoidance of conflict (overly inflexible) (Kog & Vandereycken, 1989; Wade, Bulik, & Kendler, 2001). Families affected by bulimia tend to be overly critical of each other with very few nurturing interactions (Kog & Vandereycken, 1989; McDermott et al, 2002; Wade et al., 2001). Families affected by binge eating disorder tend to be withdrawn from each other and deny warmth and acceptance (Dominy, Johnson, & Koch, 2000).

These separate bodies of research have clearly outlined differences in disordered eating behaviors by race and culture as well as family environment, yet very little attention has been given to understanding how these important variables may relate to and influence each other with respect to women's experiences with an eating disorder. For this reason, the present study sought to answer, "How do young African American, Latina, and Caucasian women describe their experiences with bulimia within their racial, cultural, and familial contexts?" Researchers have noted that comparing families based

on their cultures *and* their familial interaction patterns is important to understanding eating disorders (Haworth-Hoepfner, 2000), and cultural insight will lead to greater understanding of people's experiences with eating disorders (Crago, Shisslak, & Estes, 1996; Maine, 2006). Furthermore, it has also been noted that due to a lack of proper understanding of eating disorders in women of color, treatment manuals for eating disorders do not address the ways in which clinicians can be more culturally competent in working with families of diverse backgrounds, and so they are struggling with delivering effective treatment for minorities (Crago et al., 1996; Harris & Kuba, 1997).

The current study expanded upon previous research on eating disorders and family interaction patterns by exploring the similarities and differences of these patterns by race and culture. Thirty-three young adult African American, Latina, and Caucasian women, ages 18 to 30, who lived with their parent(s) during a portion of the time they experienced bulimia were recruited to participate in one-on-one, semi-structured in-person interviews. Utilizing feminist and family systems theories, this study explored young women's retrospective perceptions and experiences of their families before and during their experiences with bulimia through the lens of their racial and cultural identities. This project includes four chapters: (1) a thorough review of the general literature on eating disorders in families and various racial groups; (2) a comprehensive description of the study's qualitative methodologies; (3) a thick, rich narrative capturing the emergent themes in the data; and (4) a discussion of how the major findings enhance and challenge existing theories. Although the study only included participants who have been affected by bulimia, literature on families and racial/cultural groups struggling with

anorexia and binge eating disorder is also reviewed due to the many studies that include more than one type of eating disorder when isolating family, race, and culture variables.

Findings from the current study filled several gaps in the literature on women's experiences with bulimia with respect to their familial and racial/cultural contexts. First, unlike many eating disorder studies that use predominantly Caucasian samples and rarely include findings by race or culture in the discussions, this study included a racially diverse and equitable sample of women affected by bulimia, and analyzed similarities and differences by race and culture in the women's stories. Second, no qualitative studies have yet to combine family and racial/cultural contexts in the study of bulimia, and few eating disorder studies have employed the feminist framework. Also, this study used a post-modern framework for allowing women distressed by bulimia to speak about their familial experiences.

## CHAPTER 2: REVIEW OF THE LITERATURE

### Review of the Literature on Eating Disorders

#### *Prevalence*

Eating disorders have become a worldwide phenomenon, affecting men and women of all backgrounds. Yet little urgency is given to the research, prevention, and treatment of these illnesses. It is well-documented that people from as many as 40 countries are struggling with eating disorders, suggesting a global culture focused on consumerism, appearance and beauty, and women's social roles (Maine, 2006). In the United States, current statistics suggest that about 2-4% of men and women are fighting a life and death battle with an eating disorder (AED, n.d.). Their chances of dying from this illness, if left untreated, are about 1 in 5, causing eating disorders to be classified as the deadliest of all mental illnesses (Schooler et al., 2004; Walcott et al., 2003). Furthermore, at least 10% of adolescents and 25% of college-aged women suffer from sub-clinical eating disorders, in which they display symptoms of a disorder but do not meet the full diagnostic criteria (AED, n.d.).

#### *Diagnoses*

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 4<sup>th</sup> edition, text revision), there are three established diagnostic categories of eating disorders and a fourth emerging category expected in the fifth DSM edition. *Anorexia nervosa*, the first eating disorder diagnostic category, is characterized by a refusal to maintain at least 85% of ideal body weight (based on normative height and weight), an intense fear of gaining weight even though one is underweight, a disturbance



in the way weight and shape are perceived, and the absence of at least three consecutive menstrual cycles.<sup>1</sup> People suffering from anorexia can be classified into one of two specific groups, which include restricting type and binge-eating/purging type. Women with anorexia who restrict do not engage in purging behaviors (e.g. self-induced vomiting, laxatives, diuretics, enemas) during the current episode of anorexia, whereas women with anorexia who occasionally binge and purge do engage in these compensatory behaviors at times during the current episode of anorexia.

Currently, the mean prevalence of anorexia nervosa in young females in Western Europe and the U.S. is 0.3%, and the prevalence of subthreshold anorexia (one criterion short of threshold) ranges from 0.4 to 1.3% (Berkman et al., 2006). It is hypothesized that people may develop anorexia nervosa to help cope with their feelings of inadequacy, low self-worth, failure, and/or dissatisfaction. People with anorexia may also have a strong desire to be considered by others as unique, special, successful, and/or in control (Costin, 1999). This devastating illness can have profound negative effects on one's quality of life, including poor self-image, strained interpersonal relationships, unstable financial status, and weak job performance. Furthermore, anorexia wreaks havoc on one's body, often causing low heart rate, hypotension, lanugo, anemia, kidney dysfunction, cardiovascular problems, and osteoporosis. Among adolescents with anorexia nervosa who receive treatment, about 50-70% successfully recover, 20% slightly improve, and 10-20% remain chronically ill (Yager et al., 2006). Additionally, women with anorexia are 12 times more likely to die than healthy women of a similar age in the general population, making this illness the deadliest of all mental disorders (Yager et al., 2006).

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<sup>1</sup> In preparation for the DSM-V, eating disorder researchers and clinicians are currently working to modify the diagnosis of anorexia nervosa to include a gender neutral definition of the illness so as to allow for both women and men to be properly diagnosed (Walsh, 2006).

*Bulimia nervosa*, the second diagnostic category of eating disorders, is defined as recurrent episodes of binge eating which are then followed up with recurrent, inappropriate compensatory behaviors in order to prevent weight gain (e.g. self-induced vomiting, laxatives, diuretics, enemas). To meet the diagnostic criteria, one must engage in these behaviors at least twice a week for three months and the disturbances cannot occur exclusively during episodes of anorexia nervosa. Much like anorexia, people with bulimia nervosa can be classified into one of two specific groups, which include purging type and non-purging type. Women who binge and purge engage in compensatory behaviors that eliminate the food from their bodies through the use of self-induced vomiting or misuse of laxatives, diuretics, or enemas. Women who binge but do not engage in purging behaviors use fasting or excessive exercise to compensate for the intake of food; they do not regularly engage in the aforementioned purging behaviors (DSM-IV-TR, 2000).

Currently, the mean prevalence of bulimia nervosa in young females in Western Europe and the U.S. is 1.0%, and the prevalence of subthreshold anorexia ranges from 1.5 to 5.4% (Berkman et al., 2006). Survivors of bulimia tend to describe their eating disorder as a mood regulator, in which they are able to calm themselves with food during binges and then express their anger through subsequent purges (Costin, 1999). The constant purging of food can have devastating effects on the body, including swollen salivary glands, electrolyte imbalances, disrupted bowel functions, esophageal and stomach ruptures, and dental enamel erosion. Recovery rates for people receiving treatment for bulimia suggest that 50 to 70% have a chance of successfully recovering,

and 30 to 85% are likely to relapse within six months to six years after completing treatment (Yager et al., 2006).

It is important to note that people with eating disorders often vacillate between anorexia and bulimia, such that they may restrict, while at other times they may binge and purge. It is estimated that between 30-50% of all people with eating disorders will develop both anorexia and bulimia symptomatology (Costin, 1999; Yager et al., 2006). In this situation, diagnoses are based on the person's current symptoms, and a person's diagnosis may change if the symptoms change. The diagnosis of bulimia is always secondary to anorexia (Berkman et al., 2006), which means that if a girl meets the criteria for both anorexia and bulimia at the same time then she would be diagnosed with 'anorexia, binge eating/purging type,' which is essentially a combination diagnosis of both disorders. Furthermore, a diagnosis of bulimia can only be given if the criteria for anorexia are not met (Berkman et al., 2006). Interestingly, while anorexia diagnostically precedes bulimia, researchers sometimes classify people with the diagnosis 'anorexia, binge eating/purging type' as bulimic-anorexics or 'bulimarexics' and include them with other women who are diagnosed with bulimia (see Cantelon, Leichner, & Harper, 1986).

Due to the fact that so many people with eating disorders are affected by both illnesses, many empirical studies rarely include participants who have only experienced one of these four types of diagnoses (restricting anorexia, anorexia with binge-eating/purging, bulimia purging type, bulimia non-purging type). Rather, participants with restricting anorexia are often labeled as 'anorexic,' whereas samples including people with both types of bulimia (purging and non-purging) *and* anorexia, binge-eating/purging type are often classified together as 'bulimic.' Thus, while these four

groups are distinctly different based on their symptoms, diagnostically “pure” samples are rarely available for the purposes of clinical research.

The third eating disorder diagnostic category is known as *Eating Disorder Not Otherwise Specified* (EDNOS), which encompasses all atypical eating disorders that cannot be classified as anorexia nervosa or bulimia nervosa (DSM-IV-TR, 2000). At least 50% of all eating disorder diagnoses fall into EDNOS, and these disorders may include: women with anorexia who have missed their periods for less than three consecutive months, people with anorexia who are in their normal weight range, people with bulimia who do not binge or purge frequently enough to meet diagnostic criteria, people who purge and do not binge, people who chew and spit out food, and people with binge-eating disorder (Costin, 1999; Yager et al., 2006).

Of the several types of EDNOS diagnoses, binge-eating disorder has received the most attention over the past decade because of the strong positive correlation between people with binge eating disorder and obesity. Due to the increased national focus on the obesity epidemic, many researchers are interested in studying binge eating disorder. However, since it is lumped into the EDNOS diagnosis with other atypical eating disorders, it is difficult to study this disorder independently. As a result, binge eating disorder is likely to become a fourth diagnostic category of eating disorders in the fifth revision of the DSM, expected to be published no earlier than 2011. Currently, binge-eating disorder, first coined in 1992, is defined by the DSM-IV-TR (2000) as recurrent episodes of binge eating with at least three of the following five qualifications: 1) eating until feeling uncomfortably full, 2) eating large amounts of food when not physically hungry, 3) eating much more rapidly than normal, 4) eating alone because of

embarrassment about the quantity of food eaten, and 5) feeling disgusted, depressed, or guilty after overeating. People report eating a larger amount of food than is considered normal during a 2-hour period of time, and they experience marked distress during the bingeing episode. To fulfill the diagnostic criteria, binge eaters must engage in this behavior at least two days per week for six months, the use of inappropriate compensatory behaviors does not exist, and the bingeing episodes do not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Currently, binge-eating disorder afflicts about 2% of the US population, and is common among people seeking treatment for obesity (1 to 30% prevalence) (Yager et al., 2006). The excessive intake of food can have serious effects on various bodily functions, including high blood pressure, high cholesterol levels, heart disease, diabetes, and gallbladder disease (NEDA, 2002).

#### *Populations Most Likely to be Affected by Eating Disorders*

Based on clinical research and treatment program admission data, eating disorders are most likely to afflict adolescent females with specific personality characteristics who have a genetic predisposition to develop a mental illness and suffer from other mental illnesses. The following paragraphs provide a detailed review of each factor.

##### *Age*

Four out of every five people with eating disorders will develop them between the ages of 14-19 years (ANRED, 2004). Puberty is an important developmental stage for girls with regard to their body image and related eating concerns, primarily due to the rapid physical changes (e.g. breasts, fat around hips and thighs) that may no longer fit the

socially-prescribed petite and thin feminine model (Brooks-Gunn & Reiter, 1990; Striegel-Moore, Schreiber, et al. 2000). In fact, prepubescent girls report markedly lower levels of body image dissatisfaction and dieting behaviors than do girls who have experienced puberty (Striegel-Moore, Schreiber, et al., 2000). Furthermore, a study by Striegel-Moore and Kearny-Cooke (1994) found that adolescents are the most likely targets of parental criticism about their physical appearances, in comparison to parents' remarks about their preschool-age and grade-school children's bodies. In this study, the teens (ages 13-16 years) received the most negative evaluations (based on parents' self-reports) about their bodies and their behaviors from parents, in which they were the targets of the most criticism and the least amount of praise. As a result of these negative family environments, in which the teen feels scrutinized and unsupported, it is likely that close family relationships between the adolescent and other members may be strained, and conflict between members may also increase above and beyond the normal parent-child conflict associated with adolescence. Consequently, adolescents may feel as though their identities and independence are out of their control, sometimes predisposing them to turn to controlling their weight in an effort to restore a feeling of control in their lives.

### *Gender*

Approximately 90-95% of all people in the U.S. with an eating disorder are female, however the number of men engaging in eating disorder behaviors is steadily rising (ANRED, 2004; NEDA, 2002) It is believed that this gender difference is a reflection of the disparity between physical and social experiences of men and women. Physically, women are simply more likely than men to be classified as "overweight," particularly during puberty when girls develop twice as much body fat as boys, even

though they may not look overweight (Neff, Sargent, McKeown, Jackson, & Valois, 1997; Striegel-Moore, Silberstein, & Rodin, 1986), which is in sharp contrast to society's expectation of women being small and thin (Maine, 2006). As a result, girls and young women receive messages that they are not small enough and that they weigh too much, ultimately leading to behaviors aimed at controlling one's weight (Rand & Kuldau, 1990). In one study comparing boys' and girls' perceptions of their weight status, 52% of girls who rated themselves as overweight were actually a healthy weight, compared to only 25% of healthy-weight boys who considered themselves to be overweight (Marx, 2000). A similar study conducted by the Centers for Disease Control and Prevention (CDC, 2000) found that 35% of all high school girls considered themselves to be overweight, even though only 10% of them were actually overweight as measured by their Body Mass Index scores. As a result of this gender disparity in body image perceptions, boys and girls seem to be dieting at different rates. One study found that 37% of early adolescent girls (n=619) reported having dieted at least once, whereas only 15% of early adolescent boys (n=587) had dieted (Wertheim, Martin, Prior, Sanson, & Smart, 2002). Likewise, girls are much more likely than boys to use diet pills in an effort to control their weight (Johnston, O'Malley, & Bachman, 1999). In fact, teen boys are less likely than girls to diet and want to lose weight, and more likely to want to gain weight in an effort to build more muscle and body mass (Muris, Meesters, van de Blom, & Mayer, 2004).

In addition to physical differences, males and females are also socialized differently with respect to relationships and appearances. Early on, young girls are encouraged to be proper and "lady-like," develop emotional attachments to others, and

aim to please others in exchange for praise and love (Maine, 2006). They learn that attractiveness is highly correlated with serving others, and pleasing others ultimately results in developing secure and loving relationships (Striegel-Moore, Silberstein, et al. 1986; Withrow, 2006). Messages from the media tend to reinforce these values, emphasizing the importance of staying attractive through weight loss methods and beauty enhancing products (Andrist, 2003; DiDomenico & Andersen, 1988). Interestingly, Costin (1999) notes that articles and advertisements concerning weight loss are ten times more likely to appear in popular women's magazines than men's magazines, which also happens to be the same ratio (10:1) of eating disorders in women to men, respectively. With this heavy emphasis on female appearances, it seems plausible that adolescent girls are more concerned than adolescent boys about looking attractive, and they also experience lower levels of self-confidence and positive self-images than do boys (Duke, 2000).

### *Childhood Abuse*

Over the past decade, an increasing amount of attention has been paid to the relationship between eating disorders and childhood abuse. Research findings have consistently suggested a positive correlation between physical and/or psychological abuse and eating disorders. For example, one study concluded that childhood physical abuse is a global risk factor for the later development of bulimia and other psychiatric conditions (Fairburn, Welch, Doll, Davies, & Connor, 1997). Another study found that among 172 patients with eating disorders, 65% had been physically abused during childhood and another 23% had been "maltreated" in their childhoods (Root & Fallon, 1988). Furthermore, one study showed that women with a lifetime history of bulimia (n=80)



reported higher rates of childhood physical and/or psychological abuse as compared to the control group (n=40) with no history of an eating disorder (Rorty, Yager, & Rossotto, 1994).

In sharp contrast to the ease with which the data on physical and emotional abuse have been accepted, research on the relationship between sexual abuse and eating disorders has been hotly debated. Various researchers have either refuted or supported the idea that sexual abuse may be associated with the later development of an eating disorder (Costin, 1999). For example, one study comparing women with anorexia, non-purging type (n=59), women with anorexia, purging-type (n=59), and women with bulimia (n=59) found that sexual abuse was not an important issue in the treatment of eating disorders (Garner, Garfinkel, & O'Shaughnessy, 1985). Furthermore, a literature review of controlled and uncontrolled retrospective studies comparing the prevalence of childhood sexual abuse in women with bulimia and control groups found no significant differences in the prevalence rates among the two groups (Pope & Hudson, 1992).

However, other studies have produced prevalence figures suggesting a strong relationship between these two variables. For example, one study reported that of their 75 patients with bulimia, 58% of them had a history of sexual trauma (Kearney-Cooke, 1988). Another study found that of 172 patients with eating disorders, 23% had been raped and an additional 28% had been sexually abused during childhood (Root & Fallon, 1988). Similarly, among 158 patients with eating disorders in another study, 40% had been sexually abused (Hall, Tice, Beresford, Wooley, & Hall, 1989). Finally, two reviews of this literature on the relationship between childhood sexual abuse and eating disorders found that the experience of childhood sexual abuse is a significant experience associated

with the development of bulimia nervosa, particularly when the person suffers from at least one other psychiatric illness (Smolak & Murnen, 2002; Wonderlich, Brewerton, Jolic, Dansky, & Abbott, 1997).

It is important to note that all of the research on the relationship between childhood abuse and the later development of an eating disorder is correlational in nature, and does not suggest a cause-and-effect relationship. Childhood abuse may not cause an eating disorder, but it has been suggested that these two experiences may be related. Many factors and variables interacting with one another play a role in how well the child will cope with the abuse, including the nature and severity of the abuse, the functioning of the child prior to the abuse, and how the child is cared for after the abuse is exposed (Costin, 1999).

#### *Personality type*

A variety of studies have identified general personality characteristics in people with eating disorders. The most commonly cited characteristics include perfectionism, obsessiveness, anxiety, affective dysregulation, moodiness, impulsivity, and low self-esteem (Costin, 1999; Halmi et al., 2005; Stice, 2002). Overall, people with eating disorders tend to be dominated by persistent feelings of not being sufficiently qualified or competent to handle the many demands of life, and they end up spending a lot of time worrying about these negative feelings. This general self-concept has been identified as a core characteristic of people with eating disorders, and has been referred to as “long-standing negative self-evaluation” in the eating disorder literature (Vitousek & Hollon, 1990).

Perfectionism has been identified as the key personality characteristic in people with eating disorders (Ruggiero, Levi, Ciuna, & Sassaroli, 2003; Sassaroli & Ruggiero, 2005; Sutandar-Pinnock, Blake, Carter, Olmsted, & Kaplan, 2003). While an excessive devotion to work and productivity at the expense of few or no leisure activities and friendships has been cited in perfectionists with eating disorders, heightened concern over mistakes seems to be the distinguishing feature of pathologic perfectionism (Frost, Marten, Lahart, & Rosenblate, 1990; Johnson, Cohen, Kasen, & Brook, 2006). This concern over mistakes translates into feelings of never doing anything well enough and all actions are accompanied by feelings of self-criticism and a sense of ineffectiveness. For adolescents, this perfectionist tendency to do things thoroughly and well enough are also linked to parental criticism, in which the child constantly strives to do things perfectly in an effort to meet the parents' high expectations and avoid parental blame and withdrawal of love (Burns, 1980; Patch, 1984; Sassaroli & Ruggiero, 2005).

Rooted in the drive to be perfect, feelings of anxiety and depression may develop as a result of not being able to meet unrealistically high standards set by oneself or others. A person may become obsessed with the need to look a certain way or behave a certain way, and so extreme methods of dieting, fasting, and other weight loss behaviors are likely to develop (Graber, Brooks-Gunn, Paikoff, & Warren, 1994; Heatherton & Baumeister, 1991; Zubieta, Demitrack, Fenick, & Krahn, 1995). Furthermore, it has been hypothesized that impaired affect regulation and depressive symptoms may lead to increased binge eating, while anxiety about potential weight gain and impulsivity may lead to increased purging in an effort to distract oneself and release anxiety-provoking

emotions (Johnson, Cohen, Kotler, & Kasen, 2002; Johnson et al., 2006; Zaidler, Johnson, & Cockell, 2002).

In addition to specific personality characteristics common in people with eating disorders, several diagnosable personality disorders have also been identified, including borderline, histrionic, and obsessive-compulsive personalities (Cooley & Toray, 2001; Johnson et al., 2006; Stice, 2002). People with borderline personality disorder and an eating disorder are often characterized by impulsive binge eating, unstable and intense interpersonal relationships, unstable self-image, an intense fear of abandonment, and chronic feelings of emptiness (APA, 2000). Histrionic personality disorder tends to include excessive emotional expression and concern about appearance. These people are constantly seeking attention from others through inappropriate seductiveness and they often crave novelty and excitement (APA, 2000). People with eating disorders who also have obsessive-compulsive personality disorder tend to have a preoccupation with orderliness, perfectionism, and control over oneself and interpersonal relationships. They are obsessed with details and organization, and often times their perfectionism interferes with the completion of a started task (APA, 2000).

The development of a personality disorder during adolescence or early adulthood is associated with the onset of recurrent binge eating, purging, recurrent dietary restriction, obesity, and eating disorders by middle adulthood (Johnson et al., 2006; Oldham et al., 1995; Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999). Furthermore, people with eating disorders who also have co-occurring personality disorders tend to have poorer treatment outcomes with respect to their eating disorder symptoms than do people with eating disorders who do not have personality disorders (Johnson et al., 2006).

### *Genetic Predisposition*

Over the past two decades, twin and family genetic studies on eating disorders have been conducted around the world, providing evidence to suggest the important role of inherited factors in the development of these illnesses. A number of several large, well-controlled eating disorder twin studies have established that the heritability of both anorexia nervosa and bulimia nervosa is somewhere between 50-85%, implying that if one twin develops an eating disorder, there is a .50-.85 chance that the other twin will also develop an eating disorder (Brewerton, 2006). It is important to note that these rates are higher in monozygotic twins, in which the two share 100% of their genes, and lower in dizygotic twins and non-twin sibling pairs, who share on average 50% of their genes (Kendler et al., 1991; Plomin, DeFries, & McClearn, 1990). Based on a review of existing twin studies, the exact combination of genetic and environmental factors is still unknown, but findings have shown that genetics may actually contribute more to the development of the illness than shared environment (Bulik, Sullivan, Wade, & Kendler, 2000).

To date, only a handful of published twin studies have explored genetic components of anorexia nervosa. The first study of twins with anorexia found that the monozygotic (MZ) twins had a concordance rate of 56%, whereas the dizygotic (DZ) twins only had a concordance rate of 7% (Holland, Hall, Murray, Russell, & Crisp, 1984). The second study, which used a population-based sample of 2,163 female twins, found that co-twins whose sister had anorexia were significantly more likely to develop anorexia, bulimia, and/or major depression at some point in their lives than were twins whose sister did not have anorexia (Walters & Kendler, 1995). Third, an analysis of

anorexia and major depression was conducted using the same group of 2,163 female twins, in which they found the estimated heritability of anorexia to be 58%; it is important to note they could not rule out the contribution of shared environment (Wade, Bulik, Neale, & Kendler, 2000). From these few twin studies, researchers have concluded that anorexia nervosa does have genetic links; however, it is recognized that future research with larger sample sizes and alternative sampling strategies, as well as studies with more power, are needed (Bulik et al., 2000).

Limited twin studies of bulimia have produced more conclusive evidence than the anorexia twin studies, suggesting a strong genetic component in the development of bulimia. Treasure and Holland (1989) compared 14 MZ and 17 DZ twin sisters in which one sister had bulimia, and found that the MZ twins' concordance rate of bulimia was 36%, while the DZ twins' rate was 29%. Similarly, Fichter and Noegel (1990) compared 6 MZ to 15 DZ twin pairs, and concluded that MZ twins had a concordance rate of 83%, while the DZ twins' rate was only 26%. Hsu, Chesler, and Santhouse (1990) compared 6 MZ twins and 2 DZ twins, and also found disparate rates, in which the MZ twins had a concordance rate of 33% whereas the DZ twins had no concordance (0%). More recently, larger studies have produced similar findings. In 1991, Kendler et al. sampled 590 MZ twins and 440 DZ twins in which one sister had bulimia and found the concordance rate among the MZ twins to be 23%, whereas the rate among the DZ twins was only 9%. Similarly, Bulik, Sullivan, and Kendler (1998) sampled 497 MZ and 353 DZ twins, and found the concordance rate of the MZ twins to be 9% while the DZ twins had no concordance (0%). Thus, as these studies suggest, genes seem to play an important role in the development of bulimia nervosa (Bulik et al., 2000). However, the wide variation in

concordance rates across studies indicates a need for further research to better understand the genetic underpinnings of eating disorders.

In addition to the strong genetic evidence provided by twin studies of eating disorders, other research on the concordance rates of mental illnesses in families in which one member has an eating disorder also implicate the role of genetics in the development of these illnesses. It is believed that women born into families with a history of mental illness, especially ones in which other members have eating disorders, are much more likely to develop their own eating disorder than women raised in families without these histories (Bulik, 1996; Kaye et al., 2004). In one study, 43% of the sisters and 26% of the mothers of women with bulimia had their own lifetime diagnosis of an eating disorder, most often EDNOS (Stein et al., 1999). Furthermore, when comparing first-degree relatives of people with eating disorders to control populations, rates of depression and substance abuse are significantly higher in the families with eating disorders than the control families (Costin, 1999). Additionally, family studies report an increased prevalence of obsessive-compulsive disorder and obsessive-compulsive personality disorder in relatives of individuals with eating disorders (Bellodi et al., 2001; Lilenfeld et al., 1998).

It is important to note that in contrast to the aforementioned twin studies of eating disorders, in which genetic contributions can be isolated from environmental influences, research on eating disorders and other mental illnesses in multiple family members does not necessarily point to a pure genetic component. Twin studies provide a unique research setting because twin pairs from shared (i.e., lived together) versus different (i.e., raised in different families) family environments can be compared, and thus conclusions

can be drawn about how much genetics may contribute to the development of these illnesses. On the other hand, studying the mental health of families, in which members' illnesses are compared and contrasted, does not distinguish between genetic and environmental factors. So, if a mother and two of her daughters all suffer from an eating disorder, this relation could be explained by environmental factors, in which one person models the behaviors and the other two mimic them; or, the girls may be genetically predisposed to develop an eating disorder. However, in spite of this limitation, when these findings of mental health transmission between and within generations are paired with twin studies that show more heritability among MZ twins than DZ twins, it seems plausible that genetics play an important role in the development of eating disorders.

### *Comorbidity*

People affected by eating disorders are also more likely to experience other mental illnesses (Striegel-Moore et al., 1986). The four most commonly comorbid illnesses associated with eating disorders are depression, anxiety, drug and alcohol addictions, and trauma (Kendler, Thornton, & Gardner, 2001; Pike, Dohm, Striegel-Moore, Wilfley, & Fairburn, 2001; Striegel-Moore et al., 1986). When examining Caucasian and African American women with eating disorders, both depression and anxiety were common comorbid illnesses for both groups (Pike et al., 2001).

Additionally, for both Caucasian and African American women, their reported levels of food restraint, fear of fat, and drive for thinness were significantly positively correlated with their levels of depression and anxiety, such that as their eating disorder symptoms increased, so too did their feelings of hopelessness and worry (Abrams, Allen, & Gray, 1993). A specific type of anxiety, obsessive-compulsive disorder (OCD), is also



frequently comorbid with eating disorders, such that as many as 60% of people with anorexia and as many as 40% of people with bulimia also have OCD (Godart, Flament, Perdereau, & Jeammet, 2002). With respect to drug and alcohol abuse, Pike and colleagues (2001) found that about 40% of Caucasian women and 23% of African American women with eating disorders reported a lifetime history of alcohol abuse/dependence. Similarly, 42% of Caucasian women and 21% of African American women with eating disorders reported drug abuse/dependence.

#### *Intersection of Race, Culture, Socioeconomic Status, and Eating Disorders*

Noticeably absent from the list of factors associated with eating disorders are race, culture, and socioeconomic status. While it is commonly believed that eating disorders only afflict Caucasian women from privileged backgrounds (which is exacerbated by research that has primarily studied this population), new research including more diverse samples suggests that these illnesses are not specific to any one group. In fact, men and women of all racial, cultural, and income backgrounds have developed eating disorders. Unlike age or gender, in which some groups are more susceptible than others to develop an eating disorder, race/culture and income seem to span the gamut.

An important issue to consider at this point is the difference between a person's race, ethnicity, and her culture. So often these three variables are used interchangeably, as though they are one in the same; however, while they often overlap, they are distinct entities. A person's 'race,' as defined by the U.S. Census Bureau (2001), includes visible traits (e.g., skin color, hair texture), whereas the term 'ethnicity' refers to a group of people who share a common origin, such as a birth country (Yinger, 1995). 'Culture' is

defined as a group of people who share similar lifestyle qualities, including beliefs, ritual practices, ceremonies, and languages (Swidler, 1986). Cultures are often inextricably linked with certain racial (e.g., ‘black culture’) and ethnic (e.g., ‘Latin culture’) groups. However, cultural groups may also be characterized by non-race/ethnic qualities, such as a particular religion (e.g., Jewish) or geographic location (e.g., Southern).

The terms ‘race’ and ‘ethnicity’ are often written together as ‘race/ethnicity’ so as to include people who share similar physical qualities and people from similar countries of origin. Thus, since African Americans and Caucasians are considered racial groups and Latinas are classified as an ethnic group, this combined terminology is most appropriate when speaking of all groups concurrently. However, in an effort to simplify the writing throughout this report, just the term ‘race’ is used to refer to African Americans, Latinas, and Caucasians. Grouping the Latinas by ‘race’ in no way minimizes their ethnic experiences, because the paired discussions of ‘culture’ address their shared experiences as people from Spanish-speaking countries (Hardy & Laszloffy, 1995).

This pairing of analyses by race *and* culture is critical when seeking to provide a comprehensive exploration of people’s experiences. As Swidler (1986) notes, culture, not race or ethnicity, is a “tool kit” for how people construct meaning in their lives, and it also can be used to understand how and why “different groups behave differently in the same structural situation” (p. 277). Therefore, simply talking about one’s race does not provide a complete interpretation of their experiences, because race cannot and should not serve as a proxy for culture; discussions of race in tandem with culture are necessary to truly understand how a person’s skin color or country of origin may influence the construction of meaning in their lives. The following review of literature, as well as the

present study, seeks to investigate the racial *and* cultural experiences of women affected by eating disorders.

### *Race and Culture*

Over the past decade, differences in eating disorders among women of various racial/cultural backgrounds have become an emergent focus of research. Regrettably, the bulk of empirical research on dieting and eating disorders has ignored racial minority populations, and of the studies in which racial minorities have been included, racial/cultural differences were often not examined and/or presented in the results (Joiner & Kashubeck, 1996). Furthermore, the growing body of research on eating disorders in racial minorities focuses heavily on African American women, and is only beginning to focus on the Latina population. Asian American, Native American, and racial minority male populations have received very little research attention (Zhang & Snowden, 1999). Additionally, due to the paucity of research in this area, the majority of studies compare a racial minority population(s) to a white, non-Hispanic population. Comparing minorities to the majority should be used with caution, as this methodology may be interpreted as the white, non-Hispanic culture serving as the standard norm, which all minorities should strive to emulate. For the purposes of this review, research primarily focusing on eating disorders in white, non-Hispanic, African American, and Latina populations is explored.

Eating disorders within the white, non-Hispanic population have primarily served as the model by which DSM diagnostic criteria has been developed. Caucasian girls tend to be concerned with their body weight and shape, even though they may be satisfied with their overall looks (Pike et al., 2001; Schooler et al., 2004; Sorbara & Geliebter, 2002). They report an intense drive for thinness, a huge fear of fat, and an overestimation

of their actual body sizes, which then leads them to try to lose weight at twice the rate of African American women, regardless of actual weight problems (Marx, 2000; Petersons et al., 2000; Sorbara & Geliebter, 2002; Striegel-Moore, Schreiber, et al., 2000). These findings have been replicated in studies, which ask adolescent females to choose from several body drawings, 1) the body that is most representative of their actual body size, and 2) which picture is most representative of their ideal body size. One study found that Caucasian, undergraduate women overestimated their actual body size and chose very thin figures as their ideal body size (Perez & Joiner, 2003). Similarly, Caucasian college-aged men also reported wishing that their girlfriends were thinner than they actually were. This is in notable contrast to the desired female sizes of African American men, in which they preferred more voluptuous, curvy female bodies (Greenberg & LaPorte, 1996).

These distorted cognitions are thought to be exacerbated by the girls' adoption of the Western standard of beauty most often depicted in popular teen fashion magazines, in which the models are typically very tall, very thin, and Caucasian. Achieving this perfect body is portrayed as bringing about a host of positive consequences, including social acceptance by peers, fulfilling intimate relationships, and a satisfying sense of personal accomplishment, to name a few (Duke, 2000). In addition, findings from qualitative interviews suggest that parents and family members of girls with eating disorders have also adopted this Westernized standard of beauty and thus have put immense amounts of pressure on their girls to diet and be thin (Thompson, 1992). As a result, the quest to be thin can become a powerful factor in the definition of a Caucasian woman's identity, particularly if she internalizes the Eurocentric beliefs about beauty and body image

(Petersons et al., 2000). Consequently, prevalence rates of both anorexia nervosa and bulimia nervosa suggest that these are common eating disorders among Caucasian women (Abrams et al., 1993; Neff et al., 1997; Zhang & Snowden, 1999).

Eating disorders within the African American population are different than those in other racial populations due to less pressure from the community to be thin and cultural differences in ideal body shapes. Within this culture, larger body sizes and curvy body shapes are preferred by both African American men and women, and reactions to thinness in females vary from acceptance to undesirable (Petersons et al., 2000; Striegel-Moore, Schreiber, et al., 2000; Walcott et al., 2003). African American women tend to reject the conventional thin feminine image and are more likely to emulate athletes, performers, and media images that depict voluptuous African American women who are socially accepted, sexually attractive, and empowered (Duke, 2000; Miller et al., 2000; Schooler et al., 2004). In the African American culture, despite the overwhelming number of Caucasian media images, average sized and heavier bodies are considered attractive and healthy, and very thin bodies are classified as “sick looking” (Duke, 2000; Striegel-Moore, Schreiber, et al., 2000; Thompson, Corwin, & Sargent, 1997; Walcott et al., 2003). As a result of this difference in attitude, most African American women report satisfaction with their bodies, low levels of dieting, and a lack of interest in striving for or achieving the Western ideal feminine physique as portrayed in the white media (Chandler & Abood, 1997; Duke, 2000; Pike et al., 2001). In fact, African American women are 20% more likely than Caucasian women to try to gain weight, rather than lose it (Marx, 2000; Pike et al., 2001; Schooler et al., 2004), and of the African American women who diet, efforts to lose weight tend to be realistic and moderate (Abrams et al., 1993).

While it is believed that African American women may be protected from the thin ideal standards of the American culture, several factors may not protect African Americans from the pressure of attaining their racial group's ideal body image, which is somewhat larger and more voluptuous than the ideal Caucasian body (Perez & Joiner, 2003). Findings suggest that African American women with low levels of self-esteem, a history of being teased about weight and body size during childhood and adolescence, and a weak racial identity are more likely to develop an eating disorder than African American women without these qualities (Akan & Grilo, 1995). Unlike Caucasian women, young African American women often grapple with mixed messages about beauty from two different cultures (Schooler et al., 2004). The dominant, Eurocentric culture promotes the notion that beauty equals thinness, which is constantly communicated to all women through various media outlets. Additionally, these women must also identify what it means to be an African American woman. As research has shown, these two messages may contradict each other, leaving the individual feeling confused and unsure. Thus, if an African American woman possesses a strong racial identity, then she is more likely to be protected from the mainstream messages about thinness and have a healthier body image than her African American counterparts with weaker racial identities (Schooler et al., 2004).

In relation to eating disorders, African Americans are more susceptible to developing certain types of eating disorders than other types. Anorexia nervosa is seemingly less common among African American females, whereas binge-eating disorder is the most likely eating disorder to develop in this population, perhaps in response to a more voluptuous cultural norm (Pike et al., 2001; Sorbara & Geliebter, 2002; Striegel-

Moore, Schreiber, et al., 2000). Research findings on bulimia nervosa in African American women have produced inconclusive findings; about half of the studies in the current review found that Caucasian women are more likely to engage in bulimic behaviors, while the other half of the studies found that African American women are equally or more likely than Caucasian women to engage in bulimic behaviors (Schooler et al., 2004; Striegel-Moore, Schreiber, et al., 2000). For example, one study found that Caucasian women are eight times more likely than African American women to meet criteria for bulimia nervosa, primarily due to cultural differences about weight and shape concerns (Pike et al., 2001). However, another study found that more African American women than Caucasian women had engaged in self-induced vomiting, use of laxatives, diuretics, and fasting to control their weight after binge eating (Striegel-Moore, Wilfley, et al., 2000). It is important to note that the majority of these reviewed studies used community samples (women, ages 18-40) that were overwhelmingly Caucasian, with an average ratio of 2.5 Caucasian women for every one African American woman, thus the results must be interpreted with caution.

Based on the limited research on eating disorders within the Latina population, it is believed that these illnesses are similar to those in the white, non-Hispanic population. There are no significant differences in the prevalence of eating disorder symptoms or in the treatment outcomes for Caucasian and Latina populations (Crago et al., 1996; Hiebert, Felice, Wingard, Munoz, & Ferguson, 1988; Zhang & Snowden, 1999). Latinas express similar, if not greater, concerns about their body shape and weight as compared to Caucasian females, and they are most likely to report the highest level of body dissatisfaction among all racial groups (Robinson et al., 1996; Striegel-Moore & Smolak,

2000). Latinas also experience high rates of obesity, similar to those of African Americans. Of the various types of eating disorders, Latinas are more likely than Caucasian or African Americans to engage in anorexia and bulimia combined (Dounchis, Hayden, & Wilfley, 2001).

It is important to note that the Latina population is thought to be uniquely situated between the Caucasian and African American cultures with respect to eating disorders. While the prevalence rates of anorexia and bulimia in the Latina population are fairly similar to the rates among Caucasians, their obesity rates are more closely aligned with the African American population (which has been linked to binge eating disorder). Thus, their chances for developing eating disorders seem to be partially rooted in the mainstream culture, and partially influenced by their racial culture (e.g., type of food, larger ideal body). Researchers have proposed one possible interpretation of these findings, which suggests that Latinas are located at some middle point on a continuum of embodied femininity and weight concern, which would help to explain why they are somewhat similar to Caucasians and somewhat similar to African Americans (Bay-Cheng, Zucker, Stewart, & Pomerlau, 2002). However, this quantitative continuum should not be mistaken for a qualitative continuum of distinct experiences, in which Latinas' unique cultural identities are appreciated and considered when studying eating disorders.

Relatively few studies have directly compared and contrasted African American, Latina, and Caucasian populations with eating disorders. Of the few studies, findings are somewhat inconsistent when compared to findings from the aforementioned studies that only study one or two racial groups at a time. Many of the studies including all three



groups reveal that the women are equally likely to consist of dieters, but an analysis of risk by race indicates that African Americans and Latinas are twice as likely as Caucasians to develop an eating disorder (Felker & Stivers, 1994). In fact, one study using a community sample of African American (n=179), Latina (n=117), and Caucasian (n=55) women found that both Latinas and Caucasians were equally likely to be diagnosed with anorexia nervosa, and Caucasians were the least likely of these three groups to be diagnosed with binge eating disorder (Fitzgibbon et al., 1998). On eating disorder inventories that assess for various symptoms in college students, African Americans consistently score the highest on appearance evaluation, body satisfaction and esteem, sexual attractiveness, and self-esteem; Latinas and Caucasians both score similarly low on these subscales (Miller et al., 2000). Furthermore, African Americans tend to estimate more accurate body sizes than do Caucasians and Latinas, who both tend to overestimate their body sizes (Miller et al., 2000). A study investigating the relationship between depression and weight concern in women ages 18 to 45 years (N=945), findings revealed that Caucasians' (n=608) and Latinas' (n=60) sense of embodied femininity and weight concern were significantly correlated with their depressive symptomatology, however this relationship was not found in African American (n=113) women (Bay-Cheng et al., 2002).

When considering the importance of race with respect to the development and detection of eating disorders, it is imperative to also explore the role of race-based stereotypes and discrimination as experienced by minority women with eating disorders. The cultural myth that eating disorders are limited to Caucasian women prevails despite the growing evidence that these disorders afflict men and women of all racial and cultural

backgrounds. Furthermore, stereotyped body images of racially diverse women, such as the petite Asian American or the heavy African American, also impair people's abilities to detect eating disorders in minorities, ultimately affecting incidence and prevalence counts of these illnesses (Gordon, Perez, & Joiner, 2002; Office on Women's Health, 2005; Petersons et al., 2000). Some researchers have also suggested that this limited focus on eating disorders in Caucasian women may partly be due to the underrepresentation of racial minorities in clinical samples involving eating disorder research (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001). As a result of this perpetuated myth, studies have shown that despite the similarities in help-seeking behaviors of Caucasian and minority women with eating disorders, girls of racial and cultural minority groups are significantly less likely than Caucasians to be asked by a physician about eating disorder symptoms, more likely to receive treatment for the related symptoms of an eating disorder (e.g. depression, malnutrition) rather than receive an actual diagnosis for an eating disorder, and less likely to be referred out for further treatment of an eating disorder (Becker, Franko, Speck, & Herzog, 2003; Cachelin et al., 2001; Office on Women's Health, 2005). These findings suggest that barriers to treatment may actually lie in the different care physicians and clinicians provide based on a person's racial culture, rather than differences in clients' behaviors among minority groups.

The first experimental study (Gordon et al., 2002) specifically designed to examine racial/cultural stereotypes about eating disorders involved the distribution of a fictitious passage about an adolescent girl, Mary, who exhibited eating disorder symptoms (e.g. skipping meals). The 160 undergraduate participants received one of

three passages that differed only with respect to the girl's identified race (Caucasian, African American, and Latina) and they answered questions about possible problems that Mary may be experiencing. Findings revealed that while the participants' races had no influence on their abilities to detect an eating disorder, Mary's race did influence the students' detection of her eating disorder. When Mary was identified as Caucasian, 93% of the participants recognized the symptoms as an eating disorder. However, when Mary was identified as Latina and African American, only 79% of the participants realized her symptoms were indicative of an eating disorder, a statistically significant difference when compared to the Caucasian students' answers. From this study, it was concluded that racial and cultural stereotypes may affect the detection of eating disorders and override the recognition of specific symptoms within an individual.

Using the same fictitious story format, a recent follow-up study (Gordon, Brattole, Wingate, & Joiner, 2006) sought to examine the impact of a client's race on clinicians' abilities to detect an eating disorder, rather than on lay people's abilities. Based on a sample of clinical psychology graduate students (n=22) and trained clinicians with mental health graduate degrees (n=69), similar findings revealed that Mary's race influenced clinicians' responses to the question, "Do you think Mary has any problems and, if so, what are they?" When Mary was identified as Caucasian, 44.4% of the participants recognized the eating disorder symptoms. Similarly, when Mary was identified as Latina, 40.5% of the participants recognized her eating problem. In sharp contrast, only 16.7% of the participants identified Mary's disordered eating symptoms when she was identified as African American. Furthermore, clinicians were more likely to suggest that Mary did *not* need to seek any form of informal or professional help when she was portrayed as

African American (16.7%) than when she was identified as Caucasian (5.6%) or Latina (0.0%). Based on these findings, the researchers concluded that clinicians may recognize eating disorders to a lesser degree in African American girls than Caucasian or Latina girls, perhaps because of racial stereotypes about certain groups (e.g. African Americans) being protected from developing eating disorders due to cultural differences.

### *Socioeconomic Status*

For the past two decades, researchers have worked to uncover how one's socioeconomic status may be related to dieting and the development of disordered eating behaviors, however mixed findings suggest a need for continued research in this area. According to a meta-analysis conducted by Gard and Freeman (1996), 8 studies have found an increased prevalence of disordered eating behaviors in higher socioeconomic groups, while 13 studies have failed to establish a significant relationship between socioeconomic levels and disordered eating.

Several studies have produced results in favor of the notion that socioeconomic status does influence one's choice to engage in disordered eating behaviors. One of the most common findings is that disordered eating behaviors are positively correlated with higher income levels, such that as incomes rise so do the amount of disordered behaviors, such as dieting, extreme exercise, and drive for thinness in adolescent females (Drewnowski, Kurth, & Krahn, 1994; Rogers, Resnick, Mitchell, & Blum, 1997; Story, French, Resnick, & Blum, 1995). In contrast, more recent studies have found an inverse correlation between socioeconomic status and disordered eating behaviors, such that as income levels increase, dysfunctional behaviors decrease. For example, one study found that 9- and 10-year-old girls in the highest income groups reported the lowest levels of

bulimic behaviors (Striegel-Moore, Schreiber, et al., 2000). Another study concluded that adolescent females (ages 12-16) attending working/middle class schools classified themselves as more serious dieters, as opposed to girls from upper-middle class schools who were more likely to report never or minimally dieting (Huon, Gunewardene, & Hayne, 2000). Story et al. (1995) also found that higher income levels were associated with lower rates of pathological weight control behaviors, such as bingeing and vomiting, among girls aged 12-20 years. Finally, Mauksch et al. (2001) found that low-income populations are more likely to suffer from an eating disorder (10%) than are higher-income populations (7%).

A second group of studies has gathered evidence to support the idea that socioeconomic status is not associated with girls' choices to engage in disordered eating behaviors, and that these behaviors affect women in all income brackets (Duke, 2000; Edwards-Hewitt & Gray, 1993; Zhang & Snowden, 1999). For example, Gibbs (1986) and Gross and Rosen (1988) found no significant differences in income levels between high school students who have or do not have bulimia, and Edwards-Hewitt and Gray (1993) were unable to find any differences in the prevalence of eating disorders related to income levels among female college students. Finally, Rogers et al. (1997) found no variation in purging behaviors, including self-induced vomiting, laxatives, and diuretics, by adolescent females' household socioeconomic levels. Data indicating that women of all socioeconomic backgrounds may struggle with eating disorders challenge the notion that these illnesses are class bound and show how women of both middle- and working-class income levels are able to symbolize their economic struggles with food (Thompson, 1992). Furthermore, Wilfley et al. (1996) recommends moving away from only

measuring socioeconomic status to examining social status in relation to eating disorders, as well, since an equal level of income or education may have very different connotations for African American versus Caucasians.

### Theoretical Approaches to Understanding Eating Disorders

Eating disorders have long been analyzed using a variety of theories, the most popular including biomedical, psychoanalytical, and sociocultural theories. When the diagnosis of anorexia was first developed in the 1870s (bulimia did not become a diagnosis until the late 1970s), a heavy emphasis was placed on the biophysical and medical components of the illness, in which the suffering person's physiological complications were only considered for treatment, and very little consideration was given to her emotional suffering related to the illness. However, within the last 30-40 years, new research on the psychological, family, and social influences has been published and treatment has been expanded to include a more holistic approach to resolving these disorders. While theories and treatment protocol for eating disorders have evolved, many U.S. health insurance companies continue to adhere to this historical medical model of eating disorders, only providing reimbursement options for the medical treatment of these illnesses with very few treatment options for psychological and emotional treatment related to the illness. Thus, once a woman with anorexia maintains 85% of her ideal body weight or a woman with bulimia stops bingeing and purging twice a week, her insurance is likely to stop paying for subsequent treatment, even if her doctors and therapists recommend further individual or family psychotherapy (Anna Westin Foundation, n.d.).

As researchers and clinicians continued to study anorexia, and subsequently bulimia and other disordered eating patterns, a psychoanalytic theory developed in

addition to the biomedical theory about the development and maintenance of these illnesses. In the 1890s, anorexia was written about in tandem with writings on hysteria, as though the two experiences were similar in nature and psychopathology. Early psychoanalysts, including Freud, emphasized the importance of regression in the face of repressed sexual impulses and oral-erotic fixations (Waller, Kaufman, & Deutsch, 1940). More contemporary psychoanalysts now implicate the role of one's personality in the development of an eating disorder, and believe that eating disorders are problems related to body image and early interactions between the mother and child, in which the mother imposes her own needs onto the child instead of helping the child to perceive and recognize his/her own sensations and needs (Bruch, 1973).

Sociocultural theories about how and why eating disorders develop are a newer lens through which these illnesses have been studied. Over a century ago, Victorian-era women sought fuller figures, which were considered beautiful and ideal at the time. At the turn of the century, slimmer figures were becoming more ideal, and by World War II the "culture of slimming" (p. 6) had dominated women throughout the U.S. (Seid, 1994). As the medical and insurance field encouraged people to lose weight in an effort to be healthier, people began to fear both looking and feeling fat. The media and fashion industries further exacerbated these messages by showcasing females with thin bodies bordering on emaciation and dainty eating habits; the bombardment of these images led consumers (particularly girls and young women) to believe that thinness equates femininity and beauty (Seid, 1994). As a result, women began to engage in risky dieting behaviors in an effort to achieve this body image and be considered beautiful (Bartky, 1999).

A natural experiment by Becker and Burwell (1999) supported the notion that media and Westernized images of beauty are the culprit behind these illnesses. In 1995, shortly after television was first introduced to Nadroga, Fiji, Becker and colleagues surveyed 63 Fijian adolescent girls (average age 17 years) about body image and physical appearance. They found that only 3% of the participants reported the use of vomiting to control their weight, and 13% of school-aged girls scored high on a test indicating the possibility of developing disordered eating. In contrast, 3 years *after* the television was introduced airing only regional shows flaunting Westernized values (from U.S., England, and Australia), the researchers interviewed 65 more girls from the same schools and found an increase in their disordered eating behaviors. Approximately 15% of the girls reported using self-induced vomiting to control their weight and 29% of them scored high on the test indicating possible development of an eating disorder. Additionally, the girls who watched television at least three nights a week were 50% more likely to consider themselves fat and 30% more likely to diet than girls who watched less television. It is important to note that this longitudinal study controlled for the girls' ages and weight, and used matched samples in the 3-year follow-up data collection. These data are in sharp contrast to traditional Fijian values, which prefer robust body shapes for both men and women, because larger bodies reflect generous feeding which is directly linked to one's social position. In fact, 84% of the village women sampled in this study were considered overweight or obese by U.S. standards. Thus, findings from this classic study have provided evidence to suggest that Westernized images of women on television may be powerful influences on girls' and women's desires to be thin and their choices to engage in disordered eating behaviors.



Within the past 30 years, newer theories have begun to explore the dynamic and complex reasons for why people develop eating disorders, rather than simply focusing on one component such as one's personality or the media. Using a more holistic framework to understand these illnesses and devise effective treatments, feminist and family systems theories consider the important roles of the individual, family, and larger cultural contexts. The next section will explore how feminist and family systems theories are important foundations for informing research and clinical work related to eating disorders; these theories were used to guide the current study.

### *Feminist Theory*

Feminist theory utilizes a macro-level approach to critically explore how women are socially, politically, and economically marginalized and/or oppressed in a male dominated culture. This theory posits that gender is a socially constructed system, in which inequitable expectations of men and women have a direct effect on how each operate within various social and cultural institutions. Gender inequities have historically afforded men the opportunity to attain social, political, and economic statuses that are far superior to women. Thus, feminist theory challenges these socially constructed beliefs, attitudes, and behaviors that limit women's access to resources and positions of power, and also recognizes the oppressive nature of other socially constructed factors such as age, race, class, and sexual orientation (Baber & Allen, 1992; Lott, 1987). Despite the many types of feminist theories (e.g. liberal, radical, postmodern), the core beliefs at the heart of them all include: (1) women are exploited and oppressed in a patriarchal culture that privileges males (particularly, Caucasian, upper, middle-class males); (2) women have the right to be empowered to change their lives; and (3) women's experiences,

values, and activities are meaningful and important, and they deserve to be acknowledged (Acker, Barry, & Esseveld, 1983). Feminists argue that unequal distribution of power across genders promotes feelings of powerlessness in women, in which they may feel as though something is intrinsically wrong with them, when in fact there is something wrong with the culture (Katzman & Lee, 1997; Nardozzi & Hranicka, 2006). In an effort to promote equal distribution of power across gender and other socially constructed variables, feminists argue that changes in social structures (e.g. employment opportunities, household roles) must occur (Piran, 2006). Marginalized populations, including women and racial minorities, are challenged to examine the expectations of the contemporary culture and become empowered to break free from the socially prescribed inequities (Faith, Pinhas, Schmelefske, & Bryden, 2003; Maine, 2006).

A cornerstone of research guided by feminist theory is the inclusion of women's subjective knowledge of their own lives. This work requires researchers to incorporate the many voices of women, affording them the opportunity to articulate their life experiences and make their own interpretations of these experiences (Lugones & Spelman, 1999; Smith, 1987; Thompson, 1992). This respectful process expands our understanding of women's actual experiences, rather than relying on distorted and false constructions set forth by the male monopoly over accounts of women's lives (Baber & Allen, 1992; Lugones & Spelman, 1999).

In light of the many strengths of general feminist theory, an important shortcoming to consider, particularly given the focus of the present study, is the lack of attention given to race with respect to women's experiences. To address this omission, two important sub-theories have since developed from the larger feminist framework

which emphasize the importance of considering sexism *and* racism in understanding women's (particularly minority women's) experiences with cultural domination and subjugation. Womanist theory, also known as Black feminist thought, was first developed in 1983 by Alice Walker to provide a theoretical framework that more accurately reflects African American women's perspectives, and considers their experiences across multiple levels of oppression that extend beyond gender. Furthermore, as Collins (1996) notes, womanist theory is generated by black women from diverse backgrounds, and so it "encourages all Black women to create new self-definitions that validate a Black woman's standpoint" (p. 224). By rejecting the collective identity offered to them by the dominant culture (e.g., Caucasian, upper-middle class males) and valuing their own knowledge and experiences, womanist theory empowers black women to resist cultural subordination (Collins, 1996).

Similar to womanist theory, Latina feminist theory (Comas-Diaz, 1988) explores how Latinas not only endure the oppressive nature of sexism as women in general, but also as women in a traditionally patriarchal culture, in which they are expected to be submissive and dependent. This "double moral standard" is embodied in the cultural beliefs of *machismo*, in which masculinity is favored over femininity, and *marianismo*, in which women are believed to be spiritually superior to men and thus capable of tolerating all adversities imposed upon them by men (Stevens, 1973). As a result of these cultural barriers impeding Latinas' abilities to fully embrace the principles of the feminist doctrine, Latina feminist theorists argue that a more holistic school of feminist thought, which would integrate women's race, ethnicity, culture, and socioeconomic status, is

necessary in truly understanding the complex lives of minority women (Comas-Diaz, 1988).

### *Application of Feminist Theory to Understand Eating Disorders*

Feminist theory is a multifaceted, non-pathologizing approach to understanding how women's oppressive, culture-bound struggles with gender, race, and acculturation may manifest as problems associated with their weight, eating behaviors, and body dissatisfaction (Akan & Grilo, 1995; Katzman, 1993). While components of the biomedical, psychoanalytic, and sociocultural approaches are included in this theory, Marilyn Lawrence (1984, 1989), a feminist theorist who has made substantial contributions to the field of eating disorders, suggests that feminist theory moves beyond a woman's obsession with food and her body and seeks to understand how women use food to cope with significant conflict and stress within a patriarchal society that values males more than females. Feminist theory seeks to understand the delicate dance many women engage in when trying to meet society's standards of femininity (e.g. thin, beautiful) while also resisting society's prescribed roles for women (e.g. submissive, inferior). Furthermore, feminists believe that these societal standards of women to be thin and beautiful are put in place by men, and that women ultimately strive to meet these standards in an effort to not only be considered beautiful, but also gain status and power, in the eyes of the opposite sex. So, rather than viewing women with eating disorders as people who are decadent, self-absorbed, and lost in their own worlds of fashion and calorie counting, feminist theory posits that women's limited access to power both within and outside her family, and disempowering and oppressive cultural behaviors, are the contexts in which these illnesses develop (Maine, 2006; Thompson, 1994a). In an effort

to give voice to the marginalized groups oppressed by eating disorders, a feminist approach considers the critical roles of gender, race, and acculturation in the development of these illnesses. To better understand how these variables inflict feelings of oppression and powerlessness on women, racial minorities, and immigrant families, each variable is explored independently.

*Gender and Trauma.* According to the World Health Organization (2000), gender is the strongest determinant of mental health stability, social position, and status. Furthermore, women are much more likely than men to suffer from depression, anxiety, somatic ailments, and comorbid conditions. Within the feminist framework, these conditions reflect gender-biased risk factors, such as increased rates of physical, emotional, and/or sexual victimization among women, decreased socioeconomic status due to lowered pay for women, and women's subordinate social roles both in the family and at work (Maier, 2006; Maine, 2006; Schwartz & Barrett, 1988). In addition to women's mental health, their social roles, positions, and status are also influenced by their gender. Women are taught at a very young age by both their families and the larger culture that success, intimacy, and security are intricately linked to their perceived levels of attractiveness and, particularly for Caucasian women, thinness, and that as women they are expected to fulfill the role of nurturing caregivers (Schwartz & Barrett, 1988). From this it has been posited that the oppressive nature of these expectations may manifest through eating disorders, in which self-starvation and purging are non-assertive, yet powerful, ways in which women try to resist their socially prescribed roles and control their families. In response to these gender-biased expectations and standards, feminist theorists argue that in order for women to stop abusing their bodies, the culture

in which women live must allow them to feel comfortable and safe, value their emotions and sensitivities, and honor their rights and values as individuals (Abrams et al., 1993; Maier, 2006).

Feminists have also been on the forefront of research connecting women's eating problems with their experiences of sexual abuse. As previously noted, it is estimated that on average about half of all women who have eating problems have been sexually abused, thus marking this experience as a significant factor associated with women's experiences of bulimia (Thompson, 1992; Wonderlich et al., 1997). Sexual victimization has been linked to body-image disturbances, lack of trust in oneself and others, confusion about bodily experiences, negative self-esteem, difficulties connecting with one's own emotions, and fear of abandonment (particularly if the abuser was a trusted caretaker of the victim) (Costin, 1999; Thompson, 1992). For many victims, food and the act of eating become a refuge from their anger and pain associated with the abuse. Restricting food through dieting often resembles an abused woman's attempt to take back control over her body, which was robbed from her during the sexual abuse. Purging often symbolizes a woman's desire to cleanse her body from the abuse and get rid of the anger pent up inside. Binge-eating often serves the purpose of denying emotions by numbing oneself with food, and may even lead to an overweight or obese body that may be considered sexually undesirable by future predators. For all of these women, food becomes their trusted companion helping them to ignore painful emotions in solitude, and the healing process is often very slow as the many layers of trauma are carefully unwrapped and processed (Thompson, 1992). This feminist construction of how abuse is closely linked with women's issues of food and body image take eating problems out of the realm of a

“disorder,” and move them into a less pathologizing realm of “coping mechanisms” (Thompson et al., 1997).

*Race, Culture, and Discrimination.* A critical analysis of eating disorders and race/culture using the general feminist, womanist (Walker, 1983), and Latina feminist (Comas-Diaz, 1988) frameworks suggests that for racial minority women, the intersection of their racial culture with the dominant culture may create an oppressive and conflicting set of values about how one attains power through attractiveness. In the dominant Eurocentric culture, thin women are considered more attractive and beautiful than non-thin women, and attractiveness and beauty are intricately linked to a woman’s sense of power and mobility in her roles as a partner, mother, and employee. However, racial minority women (e.g. African Americans, Latinas) live in a bicultural context in which they are likely to experience conflicting cultural demands between the dominant, Eurocentric culture and their racial culture (Harris & Kuba, 1997; Kuba & Harris, 2001; Petersons et al., 2000). For example, an African American woman may be caught between the dominant culture that values thinness, and her racial culture that values voluptuous, curvy bodies. If she adopts a thin body, she has the potential to weaken the oppressive racial/cultural barrier by aligning with the valued body type of the dominant culture and potentially increasing her power and control as a minority woman, while denying her cultural values. Her parents may even encourage thinness in an effort to shield their daughter from discrimination against fat people, since they know it is virtually impossible to protect her from racism (Thompson, 1992). However, if she adopts a voluptuous and curvy body, then she has seemingly aligned with the valued body type of her family’s culture, while sacrificing an opportunity to be perceived as

attractive by the dominant culture, which ultimately may have provided her more opportunity for power and control within her social spheres.

This cultural conflict and identity confusion experienced by racial minority women has been theorized to serve as an underlying source of eating disorders, in which a woman's definition of beauty and attractiveness is initially guided by her racial culture, but comes in conflict with another definition asserted by the dominant culture. As a result, this struggle to understand how she can regain her power is internalized, and then outwardly manifested as disordered patterns of eating (Harris & Kuba, 1997; Piran, 2006; Walcott et al., 2003). As a result, it is clear that Caucasian women may develop an eating disorder for different reasons than African American or Latina women, and as such, research must continue to deconstruct this notion of a bicultural context to understand how and why minority women may be susceptible to developing eating disorders.

*Acculturation.* Limited research on minority immigrants and eating disorders suggests that levels of acculturation and endorsement of U.S. societal values regarding attraction are positively related to women's chronic dieting and disordered eating, particularly in the Latina and Asian American immigrant populations (Cachelin et al., 2003; Crago et al., 1996; Gordon et al., 2002). Acculturation refers to the process of assimilating into a culture different than one's own culture, with the goal of minimizing differences between the two (Perez, Voelz, Pettit, & Joiner, 2002). The tension and anxiety associated with this changing of cultures (e.g. threats to racial identity, culture-specific values, role conflict), known as acculturative stress, has a positive correlation with mental illness, such that as stress levels associated with acculturation rise so do mental illnesses in the people working to become acculturated (Bulik, 1987; Chance,



1965; Perez et al., 2002; Wilfley et al., 1996). Thus, the feminist framework suggests that as immigrant women are thrust into a new culture with different values and roles, they often experience a decrease in power and control, as well as an overwhelming feeling of ambiguity and confusion. In response to this acculturative stress, and in conjunction with their desire to adopt the new culture's values (e.g. thinness equals happiness and success) so as to regain their power and social status, women are susceptible to regressing to a more primitive form of communication, in which they express this internal struggle through food and dieting (Bulik, 1987; Grinberg & Grinberg, 1984).

It is important to note that while it has been shown that racial minorities born in the U.S. to immigrant parents are more likely than minorities who immigrated to the U.S. to develop an eating disorder, both immigrant groups are vulnerable to developing these illnesses (Lopez Blix, & Blix, 1995; Popkin & Udry, 1998). It is well-understood that when there are conflicting cultural demands, which are present in both first- and second-generation immigrant families, eating disturbances are more likely to occur in racial minority women than when there are little or no conflicting cultural demands (Kuba & Harris, 2001).

#### *Use of Feminist Theory in Eating Disorder Research*

Despite the important cultural and political context in which this theory frames eating disorders, there remains a resistance to feminist scholarship among eating disorder researchers and clinicians (Brewerton, 2006; Maine, 2006). In fact, a recent search of three popular research databases by Brewerton (2006) revealed that since 1966, there have been about 21,000 published articles on eating disorders, and only 0.16% of them used feminist theory in some form – 91% (n=33) were purely theoretical in nature, and

the remaining 9% (n=3) generated data. In light of the paucity of research using feminist theory, the few studies that have been conducted provide strong evidence in favor of this theory's conceptualization of eating disorders with respect to oppressive gender roles and expectations. For example, Martz, Handley, and Eisler (1995) found that women who rigidly adhered to traditional feminine gender roles (which include cultural ideas about feminine behavior and beauty) were more likely than women who did not rigidly adhere to these roles to develop eating disorders and body image problems. Furthermore, Frederick and Grow (1996) found that women with lower levels of autonomy and self-esteem were more likely to report eating disordered attitudes and behaviors than were women with higher levels of autonomy and self-esteem. Snyder and Hasbrouck (1996) found that college women who subscribed to traditional female roles were more likely to have a distorted body image and disturbed eating habits than the women who identified with feminist values and less traditional gender roles. Finally, Haworth-Hoepfner (2000) studied the role of culture and family on women's experiences with eating disorders and used feminist theory to strengthen their findings, which revealed that these illnesses unfolded amidst controlling home environments and social pressures to be thin (Haworth-Hoepfner, 2000).

The overall lack of feminist-based research is unfortunate, because as Maine (2006) notes, a feminist approach can uniquely marry the psychology of eating disorders with a complex understanding of women's personal and cultural experiences that may influence their experiences with an eating disorder. In addition, while the superficial focus on body and appearance may coexist with the development of eating disorders, feminists argue that they certainly are not the essence of these illnesses. Rather,

deconstructing body image distortions and eating disorders through the lens of relationships, gendered roles, societal expectations, and race/culture may be at the true core of these illnesses (Greenspan, 1983; Katzman & Lee, 1997). Ultimately, feminism provides an important contextual framework through which these gendered illnesses are legitimized as true coping mechanisms, while also considering the internal and societal struggles experienced by women of all backgrounds whose voices are so often silenced amidst the research (Katzman & Lee, 1997; Micale, 1995).

### *Family Systems Theory*

Family systems theory uses a micro-level approach to understand how relationships within the family and between the family and social environment may influence members' development and overall family functioning. This theory is rooted in general systems theory (Bateson, 1979; von Bertalanffy, 1968), which was founded on the assumptions that a total cybernetic system is greater and different than the sum of its parts, and that human systems are unique in their abilities to be aware of the self and others. From this general theory, the focus on families generated several key assumptions about family systems, including: all members of the family system are interconnected; understanding one member in the family requires viewing the whole family system; the family system affects its environment and the environment affects the family system; and, the family system must be flexible so that adaptations to internal and external changes can be made (Klein & White, 1996; Krauss & Jacobs, 1990; Winton, 1995). Furthermore, family systems theory emphasizes family functioning, communication, and conflict, rather than individual functioning and pathology (Whitchurch & Constantine, 1993).

Based on these assumptions of systems theory, and subsequently family systems theory, several concepts have emerged as key underpinnings of the theory, including subsystems, boundaries, and homeostasis. Subsystems are simply smaller parts of the same system. Family subsystems may include partner subsystems, parent-child subsystems, and sibling subsystems. Members' roles and functions within the family are defined by the subsystems in which the members belong, particularly with respect to their positions in the family hierarchy (Stafford & Bayer, 1993; Walsh, 1982).

Boundaries within and between family systems serve to define membership among family members and subsystems, and between entire families. Family boundaries may vary in their degree of permeability, such that some family boundaries allow more exchange of information and interactions than other family boundaries. For example, a sibling subsystem may have a very permeable boundary and allow the ongoing exchange of personal information between siblings, while the boundary between the whole family and the environment may be impermeable and not allow non-members to influence or heavily interact with the family.

Homeostasis is a steady state maintained in the family system through norms and negative feedback loops. According to this theory, family systems constantly strive to maintain homeostasis by balancing their need for change and their need to stay the same. When a family system is encouraged to change (either from an external source or an internal family member), then the family system must decide if and how to accommodate the change. If the system chooses or is forced to change, the homeostasis will be temporarily disrupted; however, once new boundaries and/or subsystems are negotiated,

the family system will develop a new state of homeostasis. If the system chooses to not change, then the current level of homeostasis will be maintained.

An outgrowth of the family systems theory is the circumplex model (Olson et al., 1989), which was developed to bridge the gap between research, theory, and clinical practice. Based on the principles of boundaries, subsystems, and homeostasis, this system-focused model integrates three core dimensions of family functioning: cohesion (balance of separateness and togetherness), adaptability (balance of stability and change), and communication (positive or negative). Each factor is considered to be highly relevant in distinguishing functional from dysfunctional family systems (see Olson & Gorall, 2003 for review of studies). According to this model, systems with balanced levels of cohesion and adaptability and positive communication skills will generally function more adequately across the family life cycle than unbalanced and negative family systems because healthy families have the resources and skills to appropriately modify their systems (Olson & Gorall, 2003).

The circumplex model has been applied in over 700 studies, making it one of the most researched family models. Additionally, the model has been used to study a variety of family systems in terms of race, marital status, family structure, sexual orientation, stage of family life cycle, social class, and educational levels (Olson & Gorall, 2003). According to Olson and Gorall (2003), the circumplex model is designed to assist researchers in determining appropriate interventions for families based on their levels of functioning and their presenting problem(s). As a result, this model has been widely used among the family research on eating disorders and is considered a sound model to guide

current studies on eating disorders and family environments (see Lundholm & Waters, 1991; Waller, Slade, & Calam, 1990).

It is important to note some drawbacks to use of the circumplex model, particularly when applying it to families affected by eating disorders. While this model is considered a guiding framework for many eating disorder studies, it certainly does not capture all of the important components of family systems, nor does it account for some of the specific qualities observed in families affected by eating disorders (e.g., heavy emphasis on physical appearance). Furthermore, some studies have also noted limitations to the circumplex model, such that higher levels of cohesion or adaptability do not necessarily have a strong positive correlation with dysfunctional qualities and overall family well-being (Barnes & Olson, 1985; Green, Harris, Forte, & Robinson, 1991). Thus, for the purposes of the present study, family systems theory in conjunction with feminist theory were the primary theories driving the methods and interpreting the results; concepts from the circumplex model were considered secondarily and used as a supplement to further investigate the roles of cohesion, adaptability, and communication in understanding women's experiences with bulimia.

Similar to the limited utility of feminist theory, family systems theory also fails to consider race and culture in understanding how families function. While this theory is helpful in identifying universal concepts found in all families, such as boundaries and hierarchies, the theory falls short in accounting for how these concepts may differ based on a family's racial and cultural context. For example, families living in an individualistic culture may value slightly more "rigid" boundaries and advocate for each person's well-being, whereas families living in a collectivist culture may display more "enmeshed"

boundaries and encourage behaviors that serve the greater good. While neither of these family systems is better or healthier than the other, the cultural differences are noteworthy and aid in a more holistic understanding of diverse family systems. Furthermore, differences in familial values among various racial groups, such as kin networks in African American families or *machismo* in Latino families, must be accounted for when seeking a solid understanding of how and why families function a particular way. To date, no known family systems theories have been developed that specifically target racial and cultural minority families.

#### *Application of Family Systems Theory to Understand Eating Disorders*

Over the past three decades, research on eating disorders has relied on family systems theory to formulate hypotheses about the function of these illnesses within a context of significant familial relationships, primarily focusing on the parent-child relationship (Killian, 1994; Sherwin, 1998). Using this theory, a plethora of research exploring family environments and the development of eating disorders has found significant relationships between these two variables, such that elevated levels of family dysfunction are more often associated with increased levels of eating disorder psychopathology, particularly during adolescence (Breiner, 2003; Haworth-Hoepfner, 2000; Wisotsky et al., 2003). A variety of family environment measures, including the Family Environment Scale (FES; Moos & Moos, 1994) and the Family Adaptability and Cohesion Environment Scale (FACES-IV; Olson, Gorall, & Tiesel, 2002), have been used to measure perceived family interactions, and findings have been able to differentiate women and families with eating disorders from control groups (Waller & Hartley, 1994). From this, it is believed that specific parental behaviors (as perceived by

the child with the eating disorder), significantly lower family functioning, and less positive family environments are related to the presence of eating disorders (Cachelin et al., 2003; McDermott et al., 2002; Waller & Hartley, 1994).

Throughout the research on relational patterns in families with a member who has an eating disorder, several common patterns have emerged that often differentiate these families from control families, including destructive communication patterns and high levels of conflict, divergent perceptions of the parent-child relationship, and a heavy emphasis on family members' physical appearances. Reports of dysfunctional communication patterns and high levels of interpersonal conflict are frequent in families in which a member has an eating disorder (Ackard & Neumark-Sztainer, 2001; Cachelin et al., 2003; Crowther, Kichler, Sherwood, & Kuhnert, 2002). Common characteristics of families with a member with an eating disorder, when compared to control families, include increased conflict paired with deficient problem-solving skills, increased expression of criticism, and decreased levels of healthy emotional expression (Ackard & Neumark-Sztainer, 2001). Based on self-reports of family interaction patterns, members tend to feel as though they cannot express their thoughts and feelings or discuss issues of disagreement, because when they do the communication escalates into conflict (Crowther et al., 2002; Kog & Vandereycken, 1989). This markedly low level of expressiveness has been found to be a significant variable in understanding how families may cope with an eating disorder (Felker & Stivers, 1994). Due to this poor communication, these families often avoid all expression of emotions, both good and bad, leading members to rate their families as mutually unsupportive, avoidant of disagreements, and unable to effectively resolve problems (Kog & Vandereycken, 1989; Striegel-Moore et al., 1986).



Through the lens of family systems theory, members' avoidance of emotional expression and conflict is one way in which they seek to maintain the family's homeostasis. By allowing members to express their thoughts and feelings, change is evoked in the system, which disturbs the status quo. Thus, by not expressing emotion, the family avoids change, which seemingly keeps stress levels down. However, the system's inflexible approach to resolving members' problems breeds hurt feelings and resentment among members and subsystems. Ultimately, the family's steady state is purposefully disrupted by a member's eating disorder, in which change is demanded and required.

While it is understood that families account for only a portion of women's experiences with eating disorders, it has been well-documented that the parent-child relationship does play a significant role in women's experiences with their illness. Adolescents with an eating disorder typically describe both of their parents as being insufficiently caring and warm, and specifically note their fathers as being overprotective (Cachelin et al., 2003; Calam, Waller, Slade, & Newton, 1990; Haworth-Hoepfner, 2000). Furthermore, these girls often feel as though their parents set impossibly high or strangely abnormal standards for success, and when the girls are able to achieve any of these standards their parents are not satisfied (Waller & Hartley, 1994). From this, daughters report feeling incompetent in their parents' eyes and also report a perceived lack of parental reciprocity, in which the parent-child relationship is strained by unrealistic expectations and unusually high standards (Wheeler, Wintre, & Polivy, 2003). Thus, these girls perceive their family systems to be inflexible and rigid. The parental subsystem has created impermeable boundaries around the family system, making it extremely difficult for the child to explore her independence and growing maturity

separate from her family. Furthermore, as she seeks to change her role in the family and establish herself as an independent woman in control of her own life, the family system resists this change and seeks to maintain its equilibrium. Consequently, her eating disorder will force the system to make changes (although not necessarily positive ones) and seemingly provide the adolescent with some form of control in her life despite the rigid and strict family environment of which she is a part.

A family's emphasis on member's outward appearances, reputations, and identities has been correlated with increased eating disorder symptomatology (Allen, 2000). Research has shown that parents' direct communication and their modeling of behaviors in relation to dieting and weight loss are the two most powerful types of parental influences on the development of an eating disorder (Wertheim et al., 2002). In comparison to control families, families in which one member has an eating disorder are more likely to model an obsessive preoccupation with weight, specifically dwelling on the value of thinness and promoting the myth that weight is strictly under one's volitional control (e.g. "If you would just stop eating..." or "If you would just exercise more...") (Haworth-Hoepfner, 2000; Striegel-Moore et al., 1986). Furthermore, dieting encouragement from either parent (regardless of parent's gender) is a strong predictor of a child's increased drive for thinness and body dissatisfaction (Wertheim et al., 2002). In fact, Thompson's (1992) qualitative interviews revealed that all of the adult women with eating disorders reported having parents who were afraid that their daughters would become fat, and were often encouraged by their parents to use diet pills in an effort to avoid growing too large. Through this parental modeling of values and behaviors, including parents' critical evaluations of their child's weight and positive reinforcement

when the child loses weight, daughters adopt the belief that being thin is valuable and under their control, ultimately rendering many of these girls vulnerable to develop an eating disorder (Crowther et al., 2002; Striegel-Moore et al., 1986; Thompson, 1992).

As this research demonstrates, family members are interconnected and all influence each other within the system. Furthermore, as family systems theory notes, the whole is greater than the sum of its parts, such that the relationships between parents and children in the context of eating disorders are more important than each member's thoughts about eating disorders. The system in which these interactions between members occur provides the foundation for treating these illnesses and healing wounded relationships and dysfunctional systems.

In addition to these relational patterns common in families with eating disorders, specific interaction patterns have also been correlated with each of the three main types of eating disorders. From this, certain constellations of family interactions can predict the type of eating disorder a person may develop. Using family systems theory, findings suggest that children's development of eating disorders is often highly associated with the families' (in)abilities to accommodate their daughters' illness and still maintain a healthy level of functioning. For example, families affected by anorexia nervosa tend to exhibit enmeshed family boundaries, in which members have very little personal space, and avoid family conflict at all costs (Kog & Vanderyecken, 1989; Wade et al., 2001). Women with anorexia tend to perceive their parent(s) as having unreasonably high standards (often in relation to weight and food), and they quickly learn that parental disapproval is inevitable (Waller & Hartley, 1994). For these girls, food becomes their

chosen device by which they can attempt to establish control of one small piece of their lives without the intrusive involvement of their parents and other family members.

Bulimia nervosa is often correlated with a lack of homeostasis and consistent boundaries. Unlike functional families who maintain healthy levels of flexibility and togetherness, families with bulimia tend to waiver from one extreme end of the continuum to the other. To exemplify this, research has shown that parents of children with bulimia are often enmeshed with criticism and hostility, such that they are overly disparaging and denigrating towards their children, but they remain disengaged from providing emotional warmth and nurturance (Kog & Vandereycken, 1989; McDermott et al., 2002; Wade et al., 2001). This combination then leads to a family system that is wrought with inconsistency and confusion. As a result, it is theorized that women with bulimia tend to interact with family members, and food, on a “yes, but” basis, such that they fluctuate between desiring and denying the relationship (Ressler, 2004; Waller & Hartley, 1994).

Binge-eating is often associated with a perceived lack of affection and nurturance in the parent-child relationship. For example, Dominy et al. (2000) studied obese women with binge-eating disorder (n=32), obese women without an eating disorder (n=51), and healthy weight women with no eating disorder (n=30), and found that the obese women with an eating disorder felt rejected by their parents, most notably their fathers, and also desired more parental warmth or acceptance. Findings such as these lend evidence to theories suggesting that women with binge-eating tend to seek comforting interactions with others on a “yes to all” basis in an effort to substitute others’ affection for the desired affection of their parents. As such, they establish and maintain relationships with

anyone who is willing to engage them, even if the relationship is unsatisfying. In relation to food, women who binge replace the missing family connections with the comfort of food, and consume extraordinary amounts, despite the fact that this behavior may lead to unsatisfying results (e.g. obesity, poor relationships) (Ressler, 2004).

As this review of family systems theory and eating disorders illustrates, a contextual understanding of eating disorder symptoms within a family system framework provides a more holistic understanding of how and why these illnesses may develop. As previously noted, families are certainly not to blame for causing an eating disorder, however the interaction patterns within these systems may affect the strength of or recovery from symptoms, both positively and negatively.

### *Synthesis of Theories*

A feminist perspective applied to family systems theory provides a useful framework to understand the familial and cultural experiences of women from different racial/cultural backgrounds with eating disorders. This unique framework considers a multitude of approaches for change and appreciates the importance of change at both personal (micro) and social (macro) levels. As Baber and Allen (1992) note:

Feminists have exploded the myth of the family as a safe and stable haven and pointed to ways in which women's lives are constrained by even their most intimate and caring relationships. Feminists have also identified ways that women resist domination and become innovators in the family nexus of caring and struggle (p. 1).

Furthermore, Maine (2006) eloquently notes that the feminist approach provides a multifaceted understanding of women's personal and cultural experiences with respect to

eating disorders, ultimately reflecting the true meaning of the systemic adage: “the whole is greater than the sum of its parts.” Feminists rightfully recognize that there is no unitary family experience for women, and without analyzing what goes on both inside and outside each woman’s family, it is impossible to understand her attitudes about her body (Baber & Allen, 1992; Thompson, 1992). Thus, while it is understood that parents and families may pass on values, expectations, and behaviors that negatively influence their child, it is also important to consider the notion that these parents are products of an unhealthy culture in which thinness and beauty are emphasized and encouraged (Maine, 2006).

To adequately explore the role of race, culture, and family interactions in the development of eating disorders, one must consider the many layers in which these illnesses are embedded. In response, the current study explored how women’s eating disorders may have been experienced in the context of family interaction patterns that fostered an oppressive and controlling environment, while considering the critical role of race and culture in understanding the development and maintenance of these illnesses. A discussion of the findings attempts to synchronize influential family and cultural factors at both the micro- and macro-levels so as to develop holistic frameworks of change for women of various backgrounds who are struggling with eating disorders.

One important limitation of this synthesis of general feminist and family systems theories is the lack of focus on individuals’ and families’ experiences of their race and culture. It is a well-known fact that people’s race and culture influence how they interact in their environments and how their families function. Fortunately, more specific feminist theories, such as Womanist and Latina feminist theories, have been developed to address

this issue, yet they remain peripheral to the dominant discourse on eating disorders. To date, no race-based family systems theories have been developed. Thus, for the purposes of the present study, Womanist and Latina feminist theories were used to provide some theoretical structure for the interpretation of the findings, yet given the paucity of popular race-based feminist and family systems theories, the current study also sought to generate new ideas and questions that may aid in the future development of race-sensitive theories.

### The Intersection of Family, Race, and Culture in Bulimia Nervosa

The present study focused on one type of eating disorder, bulimia nervosa, and so the remainder of this literature review will explore how family interaction patterns, race, and culture may be related to this specific disorder. While research on all eating disorders is valuable and necessary, there are several reasons why bulimia was singularly selected for the present study. First, bulimia is a relatively new diagnosis, introduced by DSM-III in 1980, as compared to anorexia nervosa, which has been written about for centuries and officially diagnosed in the 1800s (Morrison, 2006). As a result, there is a considerably smaller body of empirical research on this illness. Second, there is evidence that bulimia is more prevalent than anorexia. As previously noted, anorexia affects about 1% of the population, whereas bulimia affects about 4% of the population (Yager et al., 2006). Finally, as this section of the review illustrates, current findings about the prevalence of bulimia in racial minority populations are inconclusive, thus spurring the third reason for why the current study solely focuses on women with bulimia from racially diverse backgrounds.

## *Bulimia and Family Interaction Patterns*

### *General Family Interaction Patterns*

In general, research suggests that families with bulimia are easily distinguished from control families and families with a different type of eating disorder (e.g. anorexia, binge-eating disorder) based on the types of positive and negative interpersonal interactions within the family system, both before and after the eating disorder develops (Humphrey, Apple, & Kirschenbaum, 1986; Kog & Vandereycken, 1989; Strober & Humphrey, 1987). The majority of empirical literature on family functioning is based solely on patients' self-report of the family environment. Some studies have also included self-reports from family members (usually the patients' parents), while others have utilized observational techniques to track family interaction patterns (Woodside et al., 1995a). When compared to control families without an eating disorder, families with bulimia are significantly more disturbed and distressed, such that they do not interact very often, and when they do it is highly conflictual and tense (Humphrey, 1986a). To demonstrate the importance of the family environment on bulimic symptoms, one study sought to determine whether or not daily family hassles could predict intraindividual symptom variation among 20 adolescent females (average age 16 years) diagnosed with bulimia (Okon, Greene, & Smith, 2003). Using self-reports of daily hassles, findings revealed that the family disturbances only predicted bulimic episodes when the adolescent experienced them within the context of a dysfunctional family system (as perceived by the adolescent). In this study, the definition of 'dysfunctional' was guided by the circumplex model (Olson et al., 1989), in which the systems were characterized by



low levels of emotional expressiveness, high levels of conflict, and/or poor communication.

Additional research has uncovered specific interaction patterns that are unique to families with bulimia when compared to control families or families with a different eating disorder. As Crowther et al. (2002) note, families with bulimia are most often characterized by unhealthy levels of cohesion, adaptability, organization, expressiveness, and conflict. The following paragraphs review the literature on each of these constructs within families struggling with bulimia.

*Cohesion.* As previously mentioned, the circumplex model (Olson et al., 1989) is a widely used theory in research investigating family interaction patterns in families with eating disorders. Cohesion, one of the core concepts of the circumplex model (defined as the family's level of interpersonal closeness), is most often perceived as being significantly lower in families with bulimia as compared to control families, meaning that these members are very disengaged from each other (Dare, Le Grange, Eisler, & Rutherford, 1994; Johnson & Flach, 1985; Ordman & Kirschenbaum, 1986; Strober, 1981). For example, one study found that 58 patients with bulimia reported significantly less cohesion among family members than the control group (Vidovic, Juresa, Begovac, Mahnik, & Tocilj, 2005). Similarly, another study found that the women with bulimia (n=8) were significantly less likely than their parents and the control group to characterize their families as cohesive (Dare et al., 1994). Ordman and Kirschenbaum (1986) found congruent results among their sample of 25 women with bulimia, who reported markedly lower levels of cohesion than the control subjects. While studies

consistently note lower levels of cohesion among families affected by bulimia, it is important to interpret these findings with caution due to the small sample sizes.

*Adaptability.* Adaptability, which is the family's ability to appropriately adapt to changes both within and outside of the system, is a second factor in the circumplex model associated with eating disorders (Olson et al, 1989). As adolescents experience puberty and begin to want more independence from their parents and the family, the system will either accommodate that change in a functional or dysfunctional way. In families affected by bulimia, as compared to control families, research consistently finds that these adolescents report a weaker sense of self-sufficiency and autonomous differentiation from their families, indicating markedly lower levels of adaptability. For example, Vidovic et al. (2005) found that their sample of 58 women with bulimia reported significantly lower levels of adaptability than the women with anorexia and the matched controls. Furthermore, Johnson and Flach (1985) found that their sample of 105 women with bulimia reported significantly lower levels of independence within their families, and Ordman and Kirschenbaum (1986) also reported lower levels of independence and adaptability among 25 women with bulimia as compared to the control group.

*Organization.* Organization is the familial structure by which members feel a sense of order and regulation with respect to each other, planned family activities, and family responsibilities (Olson et al., 1989). Unlike healthy control families, in which the family system stays relatively organized, families affected by bulimia are often characterized by significantly lower levels of organization. For example, Humphrey (1986a) found that patients with bulimia (n=16) were significantly more likely than the control group to report disorder, disorganization, and distressing chaos in their families;

Johnson and Flach (1985) also reported greater disorganization among their sample of women with bulimia. Similarly, in a review of the literature on the characteristics of families affected by bulimia, Strober and Humphrey (1987) concluded that disorganization is a common quality among these families.

*Expressiveness.* Consistently, women with bulimia have characterized their family systems as discouraging of open, constructive expression of one's thoughts, feelings, or wishes (Humphrey et al., 1986; Ordman & Kirschenbaum, 1986; Stern et al., 1989). These families often ignore issues of disagreement and stonewall each other when conflict does arise because of their inability to manage the conflict effectively (Humphrey et al., 1986; Kog & Vandereycken, 1989; Wade et al., 2001). In fact, a study by Humphrey et al. (1986), which included 16 biologically intact families (mother, father, 18-year-old daughter with bulimia-anorexia) and 24 control families, observed families' communication patterns for 30 minutes while role-playing a discussion of the daughters' separation from the families. Upon coding the observations, findings revealed that the total percentage of confusing and contradictory communications served as a significant discriminator between families with or without bulimia, such that the families with bulimia had more dysfunctional communication patterns. Furthermore, Okon et al.'s (2003) study of the effects of daily hassles on bulimic symptomatology revealed that 42% of the women's variability in their bulimic symptoms was explained by their perceptions of low emotional expressiveness within their family systems. Ordman and Kirschenbaum (1986) theorized that the purging behaviors associated with bulimia may serve the function of expressing some of the feelings and thoughts that are not allowed to be openly expressed in the family system.

*Conflict.* In spite of families' attempts to avoid conflict, when negative thoughts are expressed they are often unregulated and are prone to quickly escalate into interpersonal conflict (McDermott et al., 2002). In contrast to women with anorexia who do not purge, women with anorexia who do purge, and control families, women with bulimia and their immediate family members frequently report dissatisfying levels of family conflict, including parent-reported marital discord and parent-child discord (Kog & Vandereycken, 1989; Wade et al., 2001; Woodside et al., 1995a). As a result of this elevated level of conflict, people with bulimia often characterize their family environments as being hostile, isolating, depriving, and disorganized (Strober & Humphrey, 1987).

#### *Parent-Child Interactions*

Much of the research on families affected by bulimia has primarily focused on the parent-child relationships, specifically investigating how the parents and child with bulimia interact. However, various findings provide different answers as to how important this relationship is in understanding women's experiences of bulimia. Bulik and Sullivan (1993) argue that the parent-child relationship is more important in understanding the differences between families fighting bulimia and control families rather than global measures of overall family environment and functioning. In contrast, Wade et al. (2001) suggest that the quality of the parent-child relationship accounts for only 2% of the development of sub-clinical bulimia symptoms. Thus, parents' roles in their children's eating disorders remain an area in need of future investigation and current findings should be interpreted with caution.

The most consistent finding throughout this body of research is the perceptions of women with bulimia with respect to their parents not being nurturing, empathic, and caring (Calam et al., 1990; Humphrey, 1986b; Strober & Humphrey, 1987). One extensive study conducted by Humphrey (1986b) included 80 young women between 15 and 23 years of age, in which 20 had bulimia, 20 had anorexia, non-purging type, 20 had anorexia, purging type, and 20 were control women with no history of an eating disorder. Using self-report measures, findings indicated that the 40 women with bulimic symptoms (20 with bulimia and 20 with anorexia, purging type), as compared to the women with anorexia and control women, reported markedly lower levels of parental nurturing, comforting, affirming, and understanding. Furthermore, the women with bulimic symptoms felt as though their relationships with their parents were much more hostile and less supportive than the control women's relationships with their parents. Consequently, when interacting with their parents, the women with bulimic symptoms reported greater blaming, attacking, withdrawing, neglecting, and walling off, and less helping and trusting than their control counterparts. These deficits in parental nurturance and comfort were specific to the women with bulimia and women with anorexia, purging type, and not considered to be true of the women with anorexia, non-purging type.

Similarly, a study by Strober (1981) compared family relations among 44 adolescent females (ages 14-17), of which 22 were diagnosed with anorexia and 22 were diagnosed with anorexia, purging type, and their parents. Using self-report measures, findings revealed that the girls struggling with anorexia, purging type were significantly more distant from their parents as compared to the women with anorexia, non-purging type. Additionally, both the mothers and fathers of the women with purging anorexia

reported significantly higher levels of discordance in comparison to their counterparts with anorexia.

A second finding suggests that adolescent girls who are raised in families that heavily emphasize the importance of maintaining an attractive physical appearance are more likely to also have symptoms of bulimia than girls whose families do not necessarily emphasize the importance of an attractive appearance. A study conducted by Rorty, Yager, Rossotto, and Buckwalter (2000) included 86 women (average age 28 years) with a lifetime history of bulimia and 573 college-aged control women. The women with bulimia cited cruel teasing about their weight by their parents, family competitions to see who could lose the most weight, and pressure from their parents to be thin as experiences strongly associated with their eating disorders. Another study suggests that girls who are raised in family environments with a lot of pressure to be attractive and watch their weights tend to form expectancies that eating will alleviate their negative feelings, that eating will lead to feeling out of control, and that their lives would be much improved if only they were thinner (MacBrayer, Smith, McCarthy, Demos, & Simmons, 2001). Consequently, these beliefs and expectancies may eventually manifest into dangerous bulimic symptoms.

Third, women with bulimia often report feeling as though their relationships with their parents are strained by inadequate boundaries. In the aforementioned study by Rorty et al. (2000), the women with bulimia reported significantly different boundaries as compared to the control women. Although the women with bulimia recognized that their parents are neither always overinvolved nor always underinvolved, they did describe specific areas of their lives in which the parents may be too intrusive or too unavailable.

For example, many of the women described their parents as being intrusively overinvolved in areas of their lives where they desired greater personal privacy and autonomy. Cited examples include the daughter's private space, personal control over her appearance (including weight and shape), and her private thoughts and feelings.

Similarly, many of the women also described their parents as being too emotionally underinvolved in other areas of their lives where they actually desired greater personal closeness, such as emotional support and autonomy-facilitating guidance. Thus, as these findings suggest, while parents of teenagers with eating disorders may not be perceived as globally over- or underinvolved, they may be considered unsuccessful in connecting with their child in a way that is nurturing and helpful for the parent-child relationship.

In addition to general trends found among parent-child relationships in families with bulimia, specific characteristics have also been noted in the mother-child and father-child relationships. In general, children with bulimia have characterized their mothers as being less maternal, less available during adolescence, less tender and loving, and less communicative with their children, as compared to mothers of healthy adolescents (Bulik & Sullivan, 1993). Furthermore, these mothers tend to relate to their daughters in a jealous or competitive way, and often show excessive concern about their daughter's eating habits, weight, and body shape during adolescence (Rorty et al., 2000).

Additionally, many children with bulimia have reported that their mothers' modeling of unhealthy eating and dieting habits has served as a significant factor in the development of their own eating disorders (MacBrayer et al., 2001; Rorty et al., 2000). In Okon et al's (2003) study, which measured the predictive ability of family hassles on bulimic symptoms, findings revealed that a staggering 45% of the symptom variability was

explained by family hassles involving the adolescent and her mother, in which the adolescent perceived this relationship to be highly conflictual.

Studies of the father-child relationship in families with bulimia reveal similar findings with respect to strained interactions. In general, women with bulimia tend to have more troubled perceptions of their relationships (e.g. more distant and alienating, less caring) with their fathers as compared to their mothers, which is in contrast to the reports of healthy daughters versus daughters with anorexia who do not necessarily make this distinction in their father-child relationships (Calam et al., 1990; Humphrey, 1986b; Woodside, Shekter-Wolfson, Garfinkel, & Olmsted, 1995b). It is important to note that this impression of a troubled relationship was not shared by the participating fathers, whose ratings of their relationships with their daughters did not differ from the mothers' ratings of their relationships with the daughter (Woodside et al., 1995b). Additionally, women with bulimia report that their fathers are more concerned than healthy daughters' fathers with their eating behaviors. Rorty et al. (2000) noted that many of the women with bulimia in their sample cited their fathers' derogatory and teasing reactions to their changing adolescent bodies as being correlated with their eating disorder. Furthermore, findings also suggest a higher level of paternal seductiveness or sexualized interactions between the father and his daughter with bulimia (Bulik & Sullivan, 1993; Rorty et al., 2000).

In sum, research on families affected by bulimia has shown that these systems are often characterized by significantly lower levels of cohesion, adaptability, organization, and expressiveness, and markedly higher levels of conflict, in comparison to control families or families affected by a different type of eating disorder (e.g., anorexia). It



should be noted that many of these family qualities also apply to children and parents managing other mental health illnesses (e.g., depression, schizophrenia), but that components of the parent-child relationship in which there is a heavy emphasis on appearance and eating behaviors may be unique to these families. Further research should continue to investigate the specific qualities or constellation of qualities that are seemingly unique to families experiencing bulimia in an effort to rule out more global qualities that characterize a broader range of families.

### *Bulimia, Race, and Culture*

Among the limited research on bulimia nervosa in various racial populations, there have been conflicting findings as to the nature of this illness among diverse racial groups. While the majority of findings suggest differences in rates of bulimia among various groups, it is unclear which group(s) may be more likely to develop bulimia. Furthermore, another body of research on bulimia and race has found no differences in racial groups' reported use of bulimic dieting behaviors. It is important to note that the research on bulimia, thus far, has primarily focused on the similarities and differences in prevalence between racial groups, with little emphasis on the cultural experiences of this illness. Thus, while many of the following studies may have included people of color, their discussions of findings often stop short of exploring the cultural factors. This review presents the extant research, which is primarily race-based, and notes when findings emphasize the cultural experiences of women with bulimia.

Research investigating the differences in bulimic symptoms by race and culture has primarily focused on the differences in Caucasian and African American women. Interestingly, some studies have found that Caucasian women are more likely than

African American women to engage in bulimic behaviors, while others have found that African American women are more likely than Caucasian women to engage in bulimic behaviors (Schooler et al., 2004; Striegel-Moore, Schreiber, et al., 2000). Edwards-Hewitt and Gray (2003) studied the prevalence of disordered eating attitudes and behaviors using a sample of 379 female college students (47% Caucasian, 36% African American). Findings revealed that the Caucasian female students reported significantly more attitudes (e.g. “I am afraid that I will not be able to stop eating voluntarily”) and behaviors (e.g. reported use of diuretics to control weight) associated with bulimia than did the African American students. Furthermore, for binge-eating behaviors (one of the two primary characteristics of bulimia), race was the only significant predictor variable, with the Caucasian students being significantly more likely to binge than the African American students. A study conducted by Pike et al. (2001) used a clinical sample of 150 women (65% Caucasian, 35% African American) whose primary eating disorder diagnosis was binge eating disorder. Their findings revealed that the Caucasian women were eight times more likely than the African American women to meet criteria for a history of bulimia nervosa. Story et al. (1995) sampled over 17,000 adolescent females (86% Caucasian, 8% African American) and found that the Caucasian females were significantly more likely than the African American females to have dieted and binged in the past year. Finally, Perez and Joiner (2003) analyzed self-reports of 96 female undergraduate university students (62% Caucasian, 38% African American), and found that race was a significant predictor of women’s bulimic symptoms, such that the Caucasian women reported significantly more symptoms than the African American women.

Yet, other studies comparing African American and Caucasian women's bulimic symptoms have found that African American women tend to exhibit more disordered behaviors than Caucasian women. For example, in the aforementioned study by Story et al. (1995), although African American females were less likely to have binged, they were more likely than Caucasian females to report having intentionally vomited after eating. In a study comparing eating disorder symptoms of 11 to 16-year-old African American and Caucasian girls, Striegel-Moore, Schreiber, et al. (2000) found that African American girls had significantly more symptoms of bulimia than did the Caucasian girls, even though they reported greater body satisfaction and a lower drive for thinness. Finally, Striegel-Moore, Wilfley, et al. (2000) used a community sample of over 7,000 adult African American (22%) and Caucasian (88%) women to study bulimia, and found that African American women reported significantly greater use of laxatives, diuretics, and fasting to control their weight than did the Caucasian women.

In addition to the research on differences in bulimic symptoms in African American and Caucasian women, a few studies have also included Latinas, American Indians, and Asian Americans in their samples. Story et al. (1995) found that twice as many Latinas reported using laxatives or diuretics to lose weight compared to females of other races, and that Latina and American Indian women were significantly more likely to use self-induced vomiting to control their weight, as compared to the Caucasian, African American, and Asian American participants. Furthermore, Perez et al. (2002) found that Latina and Caucasian females reported similar levels of bulimic symptoms, which were significantly higher than African American females' reports. Finally, Regan and Cachelin (2006) used a community-based sample of over 1,200 male and female

young adults (average age 24 years) who self-identified as Caucasian (16%), African American (16%), Asian (25%), or Latino (43%), and they found that the Asian participants were significantly less likely than the other three groups to have used laxatives, diuretics, and diet pills to control their weight.

One of the few studies that attempted to move beyond race to look at culture hypothesized that acculturation may play a significant role in women's experiences of bulimia. Perez et al. (2002) studied the role of acculturative stress and body dissatisfaction in predicting bulimic symptoms across racial groups, and found that there is a positive correlation between acculturative stress and bulimic symptoms. Furthermore, the relationship between body dissatisfaction (defined as the degree to which women consider themselves underweight or overweight relative to their racial ideal) and bulimic symptoms was intensified among minority women who reported higher levels of acculturative stress, suggesting a moderating effect of stress on body image and disordered eating behaviors (Perez & Joiner, 2003). From this research, Perez et al. (2002) concluded that the combination of acculturative stress and body dissatisfaction may make minority women vulnerable to develop bulimia; while the absence of acculturative stress may protect them from developing bulimia, even in the presence of body dissatisfaction.

In contrast to the research on differences in bulimic symptoms by race and culture, some studies have produced findings that suggest there are no significant differences. For example, Gross and Rosen (1988) surveyed over 1,300 high school students who self-identified as Caucasian (75%), African American (17%), Asian (2%), or Latino (6%). Based on the students' self-reports of bulimic behaviors, findings

revealed no statistically significant group differences between girls with bulimia and healthy girls among all four racial groups. Furthermore, in the previously cited study by Regan and Cachelin (2006), no significant differences were found in binge eating behaviors among the four racial groups, and there were no differences in reports of self-induced vomiting among the Caucasian, African American, and Latina women. Additionally, in the aforementioned study conducted by Striegel-Moore, Wilfley, et al. (2000), while African American women were more likely than Caucasian women to use laxatives, diuretics, and fasting to control their weight, they were as equally likely as the Caucasian women to engage in bingeing and self-induced vomiting. Finally, Perez et al. (2002) sampled over 100 undergraduate female students who self-identified as Caucasian (51%), African American (30%), or Latina (19%), and found that both Caucasian and Latina females reported similar levels of bulimic symptoms.

To summarize these studies, findings are inconclusive as to which racial/cultural group(s) may be more or less likely than others to engage in bulimic behaviors. Some studies suggest that Caucasian women are more likely than African Americans to binge and purge, and other studies suggest the opposite. Furthermore, some studies have found that Latinas are more likely than Caucasian and African American women to purge after bingeing, while other studies suggest that Latinas and Caucasians are virtually the same in their behaviors. Still other studies have found no significant differences in African American, Latina, and Caucasian women's bulimia behaviors. It is important to note that the majority of these studies used samples that were predominantly Caucasian, which calls into question the degree to which this disproportionate representation of races may

account for the varying results. Clearly, further research is needed to clarify the degree to which racial/cultural groups may be similar or different in their bulimic behaviors.

### *Bulimia, Family Interaction Patterns, Race, and Culture*

To date, only two known studies have investigated family interaction patterns among Caucasian, African American, and Latino families affected by bulimia. The first study (Rorty et al., 2000), included 86 women with a lifetime history of bulimia (average age 28 years) and a control comparison group of 573 women with no history of an eating disorder (average age 22 years). The clinical sample was comprised of 82% Caucasian females, and the remaining 18% self-identified as Asian American, Latina, and African American (specific percentages were not provided). The control group was 43% Caucasian, 32% Asian American, 15% Latina, and 6% African American. This study utilized one self-report measure, the Parental Intrusiveness Rating Scale, which is a 40-item scale that uses a 5-point Likert-type response format ranging from 1 (never) to 5 (always). The participants were asked to rate each of their parents (20 items about mom, 20 items about dad) as they remember them during an average year during adolescence (e.g. ages 12-17). Maternal subscales asked about invasion of privacy, jealousy and competition, and overconcern with the daughter's eating/weight/shape. Paternal subscales asked about invasion of privacy, seductiveness, and overconcern. Findings from this study revealed that women with a lifetime history of bulimia, regardless of race, reported significantly higher levels of intrusive and inappropriate parental behaviors during adolescence as compared to the control women. Further analyses by race and culture found that women from the four racial groups reported relatively similar patterns of parental behavior overall, with the one exception that Caucasian women reported

significantly higher levels of maternal jealousy and competitive behaviors than did the Asian American women. Thus, this study found no significant differences overall in family interaction patterns by race/culture in African American, Latina, and Caucasian women with bulimia; no discussion of the families' cultural contexts were expounded upon in relation to these findings.

While this recent study is an important first step in understanding how race may influence families' interaction patterns and teens' development of bulimia, there are several factors that can be improved upon. First, the diversity of the sample with bulimia is very limited, given that over 80% of the girls in the experimental group identified as Caucasian. While differences by race or culture did not seem to be the focus of this study, the limited diversity may have prevented the researchers from effectively measuring differences in family interaction patterns by race and culture, particularly in the group with bulimia. This is evident in their very limited discussion (one sentence) of similarities and differences by race, and no mention of culture. Secondly, only one self-report instrument was administered and no interviews with the participants were conducted, further limiting the researchers' abilities to fully analyze a broad range of family interaction patterns.

A more recent study (Hoste, Hewell, & le Grange, 2007) sampled 78 adolescents (ages 12-19; 76 females, 2 males) with bulimia, 69 of their mothers, and 34 of their fathers (not all parents were able to participate for a variety of reasons). All members completed the Family Adaptability and Cohesion Evaluation Scales (FACES III; Olson, Portner, & Lavee, 1985), which is a 20-item self-report measure of family cohesion and adaptability based on the principles of the circumplex model. Of the 78 adolescents, 50

were Caucasian, 10 were African American, 15 were Latino, and 3 were biracial. Due to the small sample of racial minority adolescents, they were all grouped together as “minority” (35.9%) and compared to the Caucasian (64.1%) participants. Findings revealed no differences in perceived and ideal levels of family cohesion and adaptability and overall levels of satisfaction with family functioning between Caucasian and minority adolescents, mothers, and fathers. The authors cite several limitations to their study, including a very small racial minority sample size and no measurement of acculturation. Furthermore, they note the importance of considering race *and* culture in future studies of family interactions because while these families may report similar family interactions and express similar desires for family functioning, the techniques they use to achieve these outcomes and the resources available to them may differ (Hoste et al., 2007).

### Gaps in the Literature

The present study addressed several topical and methodological gaps in the current eating disorder literature, including: (1) the lack of research combining family factors, race, and culture to better understand bulimia, (2) the limited methodologies used thus far to study bulimia, and (3) the minimal use of feminist theory in understanding eating disorders.

First, as researchers have noted, the majority of current findings about common factors found in families with bulimia have theorized about just race/culture or just family, rather than combining the factors (Haworth-Hoepfner, 2000). As a result, findings have been primarily based on interactions in only Caucasian families with eating disorders or they have only focused on racial minorities with eating disorders without



considering their family systems. Comparing families based on their race, culture, *and* interaction styles is important to understanding bulimia because the joint influence of these variables provides the most common conditions under which eating disorders are thought to develop (Haworth-Hoepfner, 2000). While the two quantitative studies by Rorty et al. (2000) and Hoste et al. (2007) have recently spearheaded this research, their small number of minority participants (18% and 35%, respectively) limited their abilities to effectively measure differences between racial/cultural groups. Furthermore, participants only completed one self-report assessment measure, further limiting the researchers' abilities to detect important family variables that may not have been properly assessed by these questionnaires. To address this gap, the present study included a racially diverse sample in which Caucasians do not outnumber minority participants and qualitative interviews allowed for a variety of cultural and familial variables to emerge that provided more insight into possible differences among the families. Additionally, the often absent voices of Latinas are well-represented in this study in an effort to provide new insight into how their experiences of bulimia may be influenced by their racial/cultural and familial contexts.

Second, the majority of eating disorder studies utilize quantitative methods to collect data. While this method has provided invaluable information about a variety of issues related to eating disorders, some researchers have noted important limitations to consider. First, since much of the quantitative research uses correlational data, Allen (2000) cautions researchers to not assume directional causality, which can be particularly important when trying to understand what *causes* an eating disorder. Second, when comparing children's and parents' self-reports of issues related to the eating disorder,

Stern et al. (1989) notes that it is important to compare these data with caution since studies have found that parents generally rate their families in a more positive manner than do their children. Third, very little qualitative research has represented the voices of women who have struggled with eating disorders. The most extensive qualitative research was completed by Thompson (1992), in which she conducted 18 life history interviews with women in recovery from eating disorders who self-identified as African American, Latina, or Caucasian. The questions focused on what it feels like to turn to food for comfort, how the women came to see their bodies as liabilities, and what resources they found to be the most helpful in developing sane relationships with food and their bodies. Findings revealed that minority women considered the role of culture, race, class, sexuality, and childhood sexual abuse as important factors that were related to their experiences with their eating disorders. For these women, the journey to recovery was very lonely and fueled by the slow identification of painful memories and feelings often numbed by the eating disorder.

Another important qualitative study included 32 open-ended interviews with Caucasian, middle-class women ages 21 to 44 (Haworth-Hoeppner, 2000). Questions focused on the role of culture and family in the development of their eating disorders. Findings revealed that the women's eating disorders emerged in the context of four conditions, including a critical family environment, coercive parental control, an unloving parent-child relationship, and a family emphasis on weight. While it is likely that each of these factors independently could predict a variety of internalized (e.g., depression) or externalized (e.g., conduct disorder) problems, this unique combination of conditions may be more associated with eating disorders than with other illnesses. It was

noted by the authors that different families mediate culture in divergent ways, and that culture and family must be considered in tandem when understanding the development and maintenance of eating disorders.

Other qualitative eating disorder studies primarily focus on the patients' perspectives of inpatient treatment experiences and their processes of recovery and relapse. An evaluation of samples in all of these studies reveals that only two noted the inclusion of racial minorities (Colton & Pistrang, 2004; Thompson, 1992), three used exclusively Caucasian samples (Haworth-Hoepfner, 2000; Keski-Rahkonen & Tozzi, 2005; Pettersen & Rosenvinge, 2002), and three made no mention of the participants' races (Cockell, Zaitsoff, & Geller, 2004; Hsu, Crisp, & Callender, 1992; Woodside, Kohn, & Kerr, 1998). To address the lack of qualitative methodologies among eating disorder research, the current study utilized 33 interviews with women who have experienced bulimia in an effort to give voice to the unique struggles experienced by people of diverse backgrounds.

Finally, in spite of its post-modern approach to understanding the complex dynamics associated with the development of and recovery from an eating disorder, the feminist approach is rarely used as a framework for eating disorder research. As Thompson (1992) notes, feminist theory appropriately considers the omnipresent roles of culture, class, and sexuality as important influences on women's understandings of their bodies. However, while eating disorder literature has embraced the post-modern notion that women's bodies serve as templates on which cultural, political, and racial conflicts occur, researchers rarely investigate these variables and instead continue to focus primarily on women's body sizes and appetites as the foundations of these illnesses

(Bordo, 1990; Katzman & Lee, 1997; Turner, 1984). In response to this lack of empirical application of feminist theory in eating disorder research, the present study was guided by feminist theory applied to a family systems framework.

In sum, the present study attempted to fill several gaps in the current literature on differences by race and culture in family interaction patterns of families with bulimia. To date, only two known quantitative studies have conducted cursory investigations of family interaction patterns with racially diverse samples (Hoste et al., 2007; Rorty et al., 2000), and no qualitative studies have yet to combine family interaction styles, race, and culture in the study of bulimia. While Thompson's (1992) study includes a racially and culturally diverse sample, there is little exploration of family factors that may have influenced the eating disorder, and Haworth-Hoepfner's (2000) family study only includes Caucasian participants. Furthermore, few studies on bulimia have included diverse samples and only a handful of studies have been guided by the feminist framework. In response to this lack of racially diverse qualitative research on bulimia, this study used family systems and feminist theories to explore the roles of family, race, and culture in the development of and recovery from bulimia using a diverse sample of women.

Based upon these gaps in the literature, the research question guiding the current study was: How do young African American, Latina, and Caucasian women describe their experiences with bulimia within their racial, cultural, and familial contexts? More specifically, this study sought to understand how women perceive their family relationships before and during their experiences with the eating disorder, as well as how their culture was perceived to influence their and their families' abilities to cope with

bulimia. Findings from this study have implications for further research, policies, and clinical approaches to the treatment of eating disorders.

## CHAPTER 3: DESIGN & METHODOLOGY

### Overall Strategy and Rationale

Rooted in the principles of symbolic interactionism, qualitative research seeks to richly describe the complex ways in which people in various contexts think, behave, and create meaning (Ambert, Adler, Adler, & Detzner, 1995; Daly, 2007; Patton, 2002). Unlike the positivist approach of quantitative research, which seeks to obtain statistically significant relationships among predetermined variables, qualitative research uses rigorous methodologies to explore *how* and *why* particular phenomena affect people's lives – data that are not always accessible from a simple survey or questionnaire (Creswell, 1998). Using a flexible, emergent design, qualitative researchers adapt their designs and inquiries throughout the process of data collection as their understandings of particular phenomena deepen or change. Adaptations may include pursuing new variables of interest as they emerge, including more or fewer participants based on saturation levels, or modifying interview questions to better explore a particular concept (Patton, 2002). Unlike quantitative data, which represent subjects and variables numerically, qualitative data use words and images to create thick, detailed descriptions of people's perspectives and experiences (Daly, 2007; Patton, 2002). To do this, qualitative researchers attempt to understand and empathize with participants' experiences to the degree that they are able to capture the meanings and emotions of the studied phenomenon (Patton, 2002).

In the current study I employed a qualitative methodology for three primary reasons. First, as many researchers have noted, qualitative methods and data complement the fundamental principles of both feminist and family research. Feminist scholars

consider qualitative research to be very important because it provides women an opportunity to voice their personal experiences. By listening to women's stories and writing about them, their experiences are legitimized and no longer invisible or unnoticed (Ambert et al., 1995; Daly, 2007; Kuba & Harris, 2001; Ragin, 1994). This knowledge about women's experiences can then be used to create change at individual, family, and cultural levels, as this study seeks to do (Patton, 2002). Additionally, qualitative research contributes to a deeper understanding of the fundamentals of family life, in terms of the diverse processes by which families create meanings and subjectively interpret their relationships and familial environments (Daly, 2007; Gilgun, Daly, & Handel, 1992). The combination of these two frameworks within the context of qualitative research provides a culturally sensitive approach to understanding people's diverse experiences within their families.

The second reason for why I used qualitative methodologies is based on Patton's (2002) advice that the researcher should "do it because you want to and are convinced it's right for you" (p.34). As a licensed couple and family therapist who treats women with eating disorders, I am deeply committed to understanding *how* and *why* individuals may become afflicted with these terrible diseases; I do this through the process of hearing clients' stories, helping them to extract meaning from their experiences, and creating an environment that conveys respect and understanding for each person involved. There are several principles of qualitative research that also match my personal principles of quality therapy, which include: (1) recognizing and respecting each person's uniqueness; (2) nurturing equity, fairness, and mutual respect in all interactions with clients and participants; (3) collaborating with people about how they want to change rather than

imposing my own beliefs about how they should change; (4) learning about people's perspectives and experiences; (5) allowing emotional experiences to transpire in our work together; and (6) remaining nonjudgmental, accepting, and supportive so as to empower people to effect change in their own lives (Patton, 2002). The qualitative emphasis on my abilities to be empathic both within an interview and a therapy session marries the research and clinical aspects of this study. As a result, this study was uniquely positioned to contribute to both bodies of knowledge.

Third, a qualitative design afforded me the opportunity to investigate a new area of research and potentially discover novel ideas and concepts. To date, there are no known available public data sets that contain quantitative information about eating disorders, race<sup>2</sup>, culture, *and* family interaction patterns. While the National Longitudinal Study of Adolescent Health (ADD Health) data set comes closest with its inclusion of race, eating/dieting behaviors, and parent-child relationship variables, it does not identify whether participants have an actual eating disorder (nor does it provide enough information for a researcher to make a diagnosis). Thus, investigation of how women's eating disorders may be related to their familial and cultural experiences is not possible. For this reason, qualitative research served the purpose of discovery and providing preliminary data about this topic; perhaps future quantitative studies will produce large data sets, which will include all of these variables together.

Modified grounded theory is the qualitative approach that was used in the current study. Pure grounded theory, developed in 1967 by Glaser and Strauss, emphasizes the process of researchers suspending preconceived ideas about a specific topic or

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<sup>2</sup> The reader is reminded that the decision was made to only use the terms 'race' and 'culture' when exploring the racial, ethnic, and cultural experiences of the participants. Refer to page 23 for a more detailed explanation of this decision.



population, and allowing phenomena and theory to emerge from the data rather than strictly interpreting the data within the parameters of a pre-determined theory (Daly, 2007; Strauss & Corbin, 1990). Through the simultaneous use of both inductive and deductive analytic processes, grounded theorists listen for clues about the salience of key issues, which then provide direction as to the types of questions that should be asked to truly develop a grounded theory (Daly, 2007; Patton, 2002). Theoretical findings that emerge from qualitative data are subject to change, just as participants' experiences and stories are expected to change over time (Daly, 2007).

A more recent adaptation of pure grounded theory is often referred to as *modified* grounded theory, which seeks to interweave the concepts of a pre-existing theory with the emergent theoretical concepts steeped in the qualitative data. This process begins with an explicit theoretical perspective, which in this study is the combination of feminist and family systems theories, which is then used to direct the initial creation of the interview questions and interpretation of findings (Patton, 2002). Theoretical concepts from feminist and family systems theories (e.g. lack of power, family relationships) served as *sensitizing concepts*, which are ideas that merely suggest a direction along which to develop interview questions and organize and analyze the data (Daly, 2007). However, while questions were developed with these concepts in mind, the questions did not specifically ask about the women's lack of power, or specific relationship dynamics with each family member. Instead, open-ended questions asked the women to describe their relationships with their parents or to describe their experiences with an eating disorder as a minority. These questions were developed in such a way that the sensitizing concepts could emerge, however other related or unrelated concepts unexpectedly developed that

ultimately contributed to a more holistic theoretical understanding of the topic or population being researched. As a result, modified grounded theory allows the researcher to develop a substantive theory, which is a theoretical explanation unique to a specific empirical area of inquiry, rather than a higher-level formal theory that offers explanations at a broader level (Daly, 2007). Furthermore, grounded theory allows for researchers to investigate if and how the formal theories initially used to guide the development of a study are, in fact, useful in understanding the sample and the issue being researched.

### Participant Selection and Recruitment

I recruited young adult women affected by bulimia for participation in one-on-one, semi-structured, open-ended interviews. Inclusion criteria for participation included being a self-identified African American, Latina<sup>3</sup>, or Caucasian adult woman between the ages of 18 and 30, who struggled with bulimia at some point in her life (a formal diagnosis of bulimia nervosa was not required and women did not need to be in recovery or recovered), and who lived with a parent during some portion of the time they had bulimia. I developed these eligibility criteria in an effort to conduct purposive sampling, in which certain women were selected to participate because they were considered “information rich” (Patton, 2002). I stopped recruiting participants when enough women were eligible and willing to participate; this process lasted nine months.

While most eating disorder studies recruit participants through medical facilities in which a formal diagnosis has been administered by a psychiatrist, this study was open to all women who fulfilled the criteria for bulimia, even if they had not received a formal

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<sup>3</sup> The term ‘Latina’ is used to describe all of the women in the present study who self-identified as Hispanic/Latina. However, it is important to note that one woman is originally from Spain, and so she is by definition not ‘Latina’; the remaining ten women are from a Latin American country. The choice to use ‘Latina’ instead of ‘Hispanic’ is based on the changing political climate, which opts for this term.

diagnosis. I based this decision on literature about low-income women and minority women who are less likely to be diagnosed with an eating disorder. Women with limited financial resources are inherently more likely to suffer from a mental illness (Hudson, 2005) and less likely than women with more money to seek treatment for a psychological illness, particularly when in-patient treatment programs for eating disorders average \$1,000 per day without insurance (NEDA, 2002). Similarly, as Gordon et al.'s (2002) research suggests, mental health professionals are less likely to diagnose a woman of color with an eating disorder than they are to diagnose a Caucasian woman, due to the stereotype that these illnesses do not affect minority populations. Thus, in keeping with the true spirit of feminist research, in which people from *all* backgrounds and experiences are included, I included women with or without a formal diagnosis. To ensure that all women had experienced bulimia and to uphold the integrity of the research design, women who had not received a diagnosis of bulimia were asked a series of questions about their experiences during the initial phone call, prior to scheduling an interview. These questions were drawn directly from the diagnostic criteria for bulimia nervosa from the DSM-IV-TR (2004). Questions included:

- Have you ever felt like you lost control when eating large amounts of food?
- Have you ever compensated for the large amount of calories you consumed by doing things like vomiting, taking laxatives, or exercising for several hours a day?
- Have these behaviors occurred at least twice a month for at least three consecutive months?

Based on the woman's answers, I was able to determine whether or not she met the criteria for bulimia nervosa. All but four of the women who contacted me about the study met the full diagnostic criteria for this disorder; the four women who did not meet the criteria for bulimia nervosa were not included in the present study.

I made the decision to include women who did not consider themselves to be in recovery or recovered because the process of recovery and the definition of 'recovered' are different for everyone. Some people define this as not experiencing any symptoms of bulimia (i.e. no bingeing and purging), while others do not consider themselves recovered until they have dealt with all of the psychological and emotional issues associated with their eating disorder (e.g., childhood sexual abuse, anxiety), even though they may no longer be experiencing symptoms. Still other women will never consider themselves truly recovered, likening this process to the "One day at a time" mantra from Alcoholics Anonymous. Furthermore, women who continue to experience symptoms of bulimia are still capable of reflecting on their past while living with a parent. For many women and men, eating disorders can be a lifelong battle and so to exclude people from research who do not consider themselves 'recovered' would be a mistake in truly understanding the complexity of these illnesses. My decision to include women in all stages of the disorder and recovery was corroborated by one woman's response to my question, "At this point do you considered yourself recovered?" She replied, "In recovery, I guess.....sure, we'll go with that....I'm just not sure what recovery means." As her response exemplifies, even when allowing the participant to define where she is in the recovery process does not necessarily provide a clear response, and certainly not one that is universal for all participants.

I sought young adult women between ages 18-30 for the present study because their memories of the adolescent years, the time when their eating disorders were most likely to begin, would still be “fresh” in their minds. Furthermore, since research has shown that adolescents still living at home tend to cast a more negative interpretation of their family situations than do their parents (Paulson & Sputa, 1996), it seemed likely then that young adults would be better able to provide a more balanced and realistic account of their family relationships during that time. Prior to beginning data collection, I only solicited women between the ages of 18 to 25. However, approximately three months into data collection and after nine Caucasian women but only two minority women had expressed interest in the study, an African American colleague suggested that I increase the age bracket to include women up to age 30 years. She theorized that younger minority women may be less ready to share their story than younger Caucasian women due to the cultural stereotypes and stigmas surrounding minority women’s experiences with eating disorders (e.g., perception that minority women do not have eating disorders, it is not okay for them to seek treatment for eating disorders). As a result of these stigmas, she suggested that minority women are less likely to have shared their stories or sought treatment by the age of 25; but, perhaps by age 30 they would have worked through some of the issues related to their eating disorder, and thus be more likely to share their story with a researcher (particularly a Caucasian researcher). In consideration of this suggestion, I submitted an addendum to the Institutional Review Board to increase the age criteria to 30 years, and within a few weeks the addendum was approved. In retrospect, it is questionable whether or not this suggestion actually expedited the recruitment process because the average ages of the African American

(23.9 years), Latina (24.6 years), and Caucasian (22.4 years) women were not markedly different.

I recruited participants through professional contacts, print advertising, campus-wide advertising, and online advertising. Within the first few weeks of recruitment, I sent a letter to over 100 eating disorder professionals (e.g., therapists, psychologists, nutritionists; see Appendix A) and asked each of them to distribute a flier (see Appendix B) about the study to their clients. The second form of recruitment, paid print advertising, included newspaper ads about the study that I placed in university and local newspapers throughout the Washington, DC-Baltimore metro area (see Appendix C). The third form of recruitment, campus-wide advertising, occurred at the University of Maryland, College Park, and included an email blast to all student organizations (e.g., student clubs, fraternities) with a flier about the study (see Appendix D), as well as fliers posted in academic buildings around campus. Finally, online advertising, proven to be the most lucrative of all recruitment efforts, included ads for the study posted on a nationwide classifieds site, Craigslist ([www.craigslist.com](http://www.craigslist.com), see Appendix E), and on social networking sites, such as Facebook ([www.facebook.com](http://www.facebook.com)) and MySpace ([www.myspace.com](http://www.myspace.com)). This form of recruitment accounted for half of all participant interest. I had originally planned to use snowball sampling, in which study participants identify and recruit other eligible participants, however this technique was never employed (even with a \$25 incentive for participants to refer other eligible women) because the majority of women had never shared their stories with friends and so they were not able to identify other women who may have also struggled with bulimia.

As previously noted, recruitment of minority participants proved to be a challenge that I was not expecting. In just seven weeks and with minimal recruitment efforts, 9 of the 11 Caucasian women contacted me about the study and completed the interviews. The majority of them learned of the study through their therapists. In contrast, it took me an additional 16 weeks to recruit the same number of African American and Latina participants, and this required more recruitment efforts, such as the newspaper and online advertisements. I also networked with some professionals of color in an effort to learn of other people in the community who may be able to assist me in disseminating information about the study. While none of these relationships yielded participants, a few have provided new opportunities to become more involved in the field of eating disorders (e.g., collaborating with a non-profit group for minority women with body image issues).

During the recruitment period, an interesting phenomenon occurred with respect to minority women's use of email as a way for prospective participants to remain anonymous before committing to the study. Interestingly, unlike the Caucasian women who primarily contacted me via phone, most of the minority participants contacted me via email after learning of the study. While I had not considered the value of email prior to beginning this study, it actually proved to be very advantageous in providing an identity buffer between the prospective participant and me. In fact, it was not uncommon for the minority women to email me from an account that did not display their full name or contain any identifying information in the body of the email. For example, one minority participant emailed me from an account that only listed her first and last name initials, rather than her full name. In the body of her email she expressed interest in the study and stated, "The only thing I hope to request is to remain anonymous," and she

included no identifying information. I replied with a detailed description of how I would write about her experiences in a way that would protect her identity and who would have access to the raw data. Based on this information, she opted to participate in the study. As this example demonstrates, email actually served as a helpful way for many women to express their interest in the study as well as their fears and concerns about participating, while still remaining anonymous should they opt to not participate, and for me to express empathy for their concerns and begin to build a trusting relationship with the women. This seemed to be particularly important with the minority women who had legitimate concerns about being “the only one” to come forward and disclose having an illness that is not culturally acceptable.

Additionally, once I met face-to-face with the women to conduct the interviews, many of the minority women were surprised to learn that multiple women of color who had experienced bulimia were being interviewed for this study. For example, Celestine (L) shared, “I’m kind of surprised that you said that I’m not the only one because I feel like I am; I haven’t met anyone with the same problem, the same situation.” In fact, at the request of one of the Latina participants, I shared her email address with the other Latina women so that any of them interested in meeting others who had gone through a similar battle with bulimia could connect and provide support for each other. For the current study, email proved to be a very useful medium by which the minority women could assess the research project before exposing their identity and

A total of 61 women responded to the various advertisements by contacting me via email or phone to say they were interested in participating in the study. Twenty-eight of these women were unable to participate for various reasons: 25% of the women never



replied to me after their initial inquiries; 25% lived out of the mid-Atlantic region and were not able to complete an in-person interview; 25% did not meet the criteria for the study (age greater than 30 years; did not self-identify as African American, Caucasian, or Latina; did not experience bulimia); 14% contacted me after 11 interviews were already completed within their racial group; and 11% decided to not participate after originally contacting me. I thanked each of these women for their interest in the study and, when appropriate, I informed them that they were not eligible to participate. A total of 34 women were deemed eligible for participation in the study, and all but one of them completed an interview (she scheduled an interview with me but never arrived on the set day and time, and never replied to my follow-up inquiries via phone and email).

True to the nature of qualitative research, the number of interviews that I would conduct was unknown at the onset of the study. Unlike quantitative research, which calculates the number of cases needed to fulfill a particular confidence interval and power level, qualitative research relies on the process of saturation, in which interviewing ceases when stories and theoretical concepts become redundant to the researcher. As Daly (2007) notes, saturation is achieved when the researcher is no longer “surprised” by what the participants share during their interviews. According to Daly (2007), 20-25 interviews is often a general point at which theoretical saturation is reached. I originally planned to conduct 30 interviews (10 interviews with women of each racial group); it was guesstimated that this number of interviews would allow for saturation (Creswell, 1998), in which no new thematic information would emerge from additional interviews. Although no new information emerged after I conducted approximately 20 interviews, I completed additional interviews to verify saturation. Furthermore, I conducted three

additional interviews after several Caucasian participants contacted me all at once and as a result 11 interviews were conducted. Thus, to ensure a balanced sample of minority participants, I also conducted 11 interviews with African American women and Latinas, ultimately resulting in a grand total of 33 interviews.

## Sample Demographics

### *Individual-Level Characteristics*

Demographic information for participants, organized by race, is included in Table 1. The participants included 33 women. Ages ranged from 18 to 30 years, with the average age being 23.6 years ( $SD = 3.5$ ). Eleven of the women self-identified as African American, 11 self-identified as Latina, and 11 self-identified as Caucasian. The sample was a well-educated group; most participants had completed at least some college. Three percent had completed high school, 42% were currently enrolled in college or had completed some college in the recent past (both community and 4-year institutions), 30% were college graduates and currently working, 15% were currently enrolled in graduate school, and 3% had completed a graduate degree.

All of the participants were born in the United States except for six Latinas who were born in other countries, including Chile, Dominican Republic, Ecuador, Guatemala, Mexico, and Peru. Of the minority women born in the U.S., five of them were first-generation and two of them were second-generation.

The average age of bulimia onset was 16.1 years among the total sample. Among the African American women, the average age of onset was 15.3 years; for Latinas the average age of onset was 16.5 years; and for the Caucasian women the average age was

Table 1: Summary of Demographic Characteristics

| Demographic Item                                | Research Sample         |                         |               |                  |
|---|-------------------------|-------------------------|---------------|------------------|
|   | All Participants (N=33) | African American (n=11) | Latina (n=11) | Caucasian (n=11) |
| <b>Individual-Level Characteristics</b>         |                         |                         |               |                  |
| Age of participants, in years                   | 23.6 (3.5)              | 23.9 (3.1)              | 24.6 (3.9)    | 22.4 (3.5)       |
| Level of education                              |                         |                         |               |                  |
| High school graduate                            | 3%                      | 9%                      | 0%            | 0%               |
| Some college                                    | 42%                     | 27%                     | 45%           | 60%              |
| College graduate                                | 30%                     | 46%                     | 27%           | 20%              |
| Some graduate school                            | 15%                     | 9%                      | 27%           | 20%              |
| Graduate degree                                 | 3%                      | 9%                      | 0%            | 0%               |
| Age of eating disorder onset, in years          | 16.1 (3.4)              | 15.3 (2.6)              | 16.5 (4.2)    | 17.6 (3.1)       |
| Methods of Purging                              |                         |                         |               |                  |
| Self-induced vomiting                           | 93%                     | 89%                     | 100%          | 90%              |
| Laxatives, diet pills                           | 35%                     | 22%                     | 33%           | 50%              |
| Excessive exercise                              | 28%                     | 33%                     | 22%           | 30%              |
| Affected by anorexia                            |                         |                         |               |                  |
| Before bulimia                                  | 31%                     | 29%                     | 10%           | 55%              |
| After bulimia                                   | 18%                     | 14%                     | 22%           | 18%              |
| Treatment Received                              |                         |                         |               |                  |
| Hospitalization/in-patient/intensive outpatient | 27%                     | 9%                      | 0%            | 73%              |
| Outpatient therapy                              | 60%                     | 36%                     | 54%           | 91%              |
| Family therapy                                  | 20%                     | 0%                      | 0%            | 60%              |
| Support group                                   | 33%                     | 27%                     | 9%            | 64%              |
| Nutrition counseling                            | 6%                      | 0%                      | 0%            | 18%              |
| Medication                                      | 9%                      | 9%                      | 9%            | 9%               |
| <b>Family-Level Characteristics</b>             |                         |                         |               |                  |
| Number of siblings                              | 2.2 (1.1)               | 2.3 (1.1)               | 2.5 (1.3)     | 1.9 (.0.7)       |
| Birth order                                     |                         |                         |               |                  |
| Oldest sibling                                  | 30%                     | 9%                      | 45%           | 36%              |
| Middle sibling                                  | 18%                     | 18%                     | 27%           | 9%               |
| Youngest sibling                                | 52%                     | 73%                     | 27%           | 54%              |
| Parents' Relationship Status                    |                         |                         |               |                  |
| Together at time of Bulimia onset               | 67%                     | 55%                     | 73%           | 82%              |
| Together at time of interview                   | 60%                     | 45%                     | 73%           | 73%              |
| <b>Community-Level Characteristics</b>          |                         |                         |               |                  |
| Community Type                                  |                         |                         |               |                  |
| Urban   | 20%                     | 40%                     | 20%           | 0%               |
| Suburban  | 90%                     | 80%                     | 90%           | 100%             |
| Rural   | 13%                     | 10%                     | 30%           | 0%               |
| Socioeconomic Status                            |                         |                         |               |                  |
| Lower   | 6%                      | 9%                      | 9%            | 0%               |
| Middle  | 75%                     | 82%                     | 64%           | 80%              |
| Upper   | 22%                     | 18%                     | 27%           | 20%              |

17.6 years. Among the many purging methods available, 93% of women in this sample used self-induced vomiting, 35% used laxatives or diet pills, and 28% engaged in excessive exercising. Nearly one third of the women engaged in the anorexic-like behavior, self-starvation, prior to developing bulimia; 18% of the women developed anorexia after battling bulimia. For many women, they started out using self-starvation as a way to lose weight but found that to be too difficult long-term and so they discovered that bulimia was just an “easier” way to lose weight. As Page (C) described it, “It was just like huh, well this is really easy, this is much easier than you would’ve expected and now I don’t feel bad. I’m not hungry anymore and I ate kind of and now I don’t feel gross anymore.” Sophia (L) also shared, “I grabbed a toothbrush and I like figured it out. After that I was like I have a solution to eating too much. I can eat whatever I want. That’s when it started. It doesn’t matter how much I eat, I can take care of it.”

Participants’ treatment spanned the entire gamut: 27% were hospitalized and/or received in-patient or intensive outpatient care from an eating disorder residential treatment facility; 60% received outpatient therapy from a psychiatrist and/or therapist; 33% attended eating disorder support groups; and 9% of the women took medication for eating-disorder related symptoms, such as anxiety or depression.

#### *Family-Level Characteristics*

All of the participants were raised by their biological parents, except for one woman who was adopted at birth and has never met her birth parents. Furthermore, all of the participants grew up in families with siblings. The average participant was the youngest of three children, ranging from one sibling to five brothers and sisters. Thirty percent of the participants were the oldest sibling, 18% were the middle sister, and 52%

were the youngest of the siblings. There were no only children and one of the participants had a twin sister.

Two thirds of the participants grew up in families in which their parents were living together at the time the eating disorder began, however sometime between when the eating disorder began and when the interview was conducted, two of the participants' parents had divorced. Thus, at the time of the interviews 60% of the parents were still together. Only two of the 33 women (6%) had a child; both of the children were young girls.

Of the women who received formal treatment for their eating disorders, only 20% of their families participated in family therapy with their daughter at some point during her treatment.

#### *Community-Level Characteristics*

Because the interviews were conducted in-person, all of the participants currently resided in two mid-Atlantic states (Maryland and Virginia), and Washington, DC, with one exception. One participant who lived in the southwest was visiting a friend (who also participated in the study) in the mid-Atlantic region during the holidays when she completed her interview. During the participants' childhood years, prior to the development of their eating disorders, 20% of them grew up in an urban community, 90% grew up in a suburban community, and 13% grew up in a rural area. The total percentages of women living in various communities exceeds 100% because some of the women moved during their childhood years and lived in more than one type of community. With respect to the community's socioeconomic status, 6% of the

participants described their communities as lower class, 75% lived in middle class communities, and 22% lived in upper class communities.

### Data Collection and Management

I conducted all of the 33 one-on-one, semi-structured, open-ended individual interviews with each woman in-person and in English. Forty-eight percent of the interviews took place in coffee shops (e.g., Starbucks, Cosi); 21% occurred at my office in College Park, MD; 21% were conducted at the woman's home or place of work; and 9% were completed in public parks. The average interview lasted approximately 1 hour and 45 minutes, with the shortest interview being 58 minutes and the longest interview being 3 hours and 11 minutes. All interview participants were given \$25 for their time and participation<sup>4</sup>.

I used a digital recording system to audiotape each of the interviews, and a transcription program to transcribe each interview verbatim. I transcribed 20 of the interviews myself, and I recruited four undergraduate students to work on this project with me, and they transcribed the remaining 13 interviews. To ensure reliability and consistency among the students' assistance, I trained each of them by reviewing a coding manual I wrote (included step-by-step instructions about how to open files, transcribe interviews, and save files), showing them a transcript of an interview I had previously completed, and sitting with them as they transcribed the first interview. Each of these interactions allowed for the student to ask me questions about the transcription process, such as how to code conversational words and phrases, like "um" and "you know." After all of the interviews were transcribed, I listened to a random sample of ten audio

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<sup>4</sup> This study was funded in part by the James W. Longest Memorial Award, a dissertation fellowship awarded by The Graduate School at the University of Maryland, College Park.

recordings while proofreading the transcriptions to ensure accuracy. I also took notes during and after each interview so as to capture any thoughts or reactions I had related to the content and process of the interviews, as well as to document key phrases and major points expressed by the participants. These journal entries were later used to triangulate the data.

Prior to beginning each interview, participants were emailed a copy of the interview informed consent form (see Appendix F) to review. A hard copy of the consent form was brought to the interview and I reviewed the information with each participant. They were informed that they could ask any questions before, during, and after the interview; that they could skip any questions they did not want to answer; and that they were free to withdraw from the study at any time. Each participant signed and dated the consent form after reviewing the information and asking any questions. Two of the 33 participants requested that I transcribe their interviews (and not an undergraduate student) due to confidentiality concerns; this was noted on their consent forms. Signed consent forms were kept in a locked file cabinet separate from the raw data so as to ensure participants' confidentiality.

Three of the interviews took place with other people present aside from me and the participant. The interviews with Jennifer (L)<sup>5</sup> and Lisa (A) were completed on the same day; they are best friends who experienced their eating disorders together during adolescence. While the interviews were conducted separately with each woman, they both sat at the table during the interviews and occasionally provided additional insight into their friend's experiences with her family and the eating disorder. A third interview

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<sup>5</sup> Each participant's race is identified in parentheses with an A (African American), L (Latina), or C (Caucasian).

was conducted at the residence of Margie, a 19-year old Latina. When I arrived on the morning of the interview, I was greeted by both the participant and her father. I was welcomed into their house, and the father expressed his great appreciation for my interest in hearing his daughter's story. After a few minutes of conversational introductions, the father exited the room to go upstairs. We began the interview and I assumed that we would be alone for the remainder of the time, however approximately 15 minutes into the interview, the father came downstairs into the living room where we were talking and asked for permission to join us. I agreed to his request so long as his daughter also agreed that it would be okay; she did not say either way, so he sat down and we continued the interview. Several times throughout the interview the father respectfully interrupted to add information about the family dynamics, their experiences in another country, or to ask me why I was asking a particular question (more to clarify my interest in that question than to challenge me about why I was asking his daughter about that issue). While my experiences of these three interviews were very positive and all of the women were very insightful and seemingly honest, it is difficult to know if and how the interviews may have been different had the women each met with me individually without anyone else listening to their private stories. Perhaps they would have gone into more detail about their experiences with bulimia, or perhaps they would have talked more candidly about their relationships with friends and family members. Yet, in spite of the fact that these interviews were not ideal in their settings, these experiences contribute to the "qualitative" nature of this research in which people's lives and stories are captured from all angles and in many different ways.



### *Interview Protocol Development*

I used an interview protocol designed specifically for the current study during all of the interviews. After reviewing the informed consent form, I discussed the purpose of the study with each participant. In an effort to establish a trusting and transparent relationship with the participants, I shared with each of them that I am a family therapist who works exclusively with people who have eating disorders, and that I am interested in hearing their stories with the larger goal of understanding how therapists can better meet the needs of families from diverse backgrounds seeking help for their daughters' bulimia. Some of the participants asked me how many other minority women I had interviewed, and if they were the first or only woman to contact me. After sharing my progress to date, many of them were surprised to learn that other women of color had also experienced bulimia and were willing to speak with me about their experiences, and they were also seemingly relieved that they were not the only one to come forward with their story.

The interview protocol was divided into two sections (see Appendix G for the complete interview protocol). The first section asked about the women's childhoods and familial and cultural contexts in which they grew up prior to the development of their eating disorder. I encouraged participants to describe their families in terms of the primary members who have played a significant role in their lives. They were encouraged to define 'family' however they liked, including biological members, non-biological kin, close friends, partners, and anybody else who they deemed significant in their lives. Many of the women included friends and partners as family. Next, I asked participants to think back to the time in their lives before they were affected by bulimia. Open-ended questions guided them to talk about their lives at this time: the community and school

contexts in which they developed; their relationships with their parent(s), sibling(s), and other family; cultural messages they received about body image; and their awareness of eating disorder-related issues. Questions about how members interacted remained vague, so as to allow for relevant concepts to emerge. For example, rather than asking specifically about the family's ability to adapt to change, I asked the women to tell me about the family environment in which they grew. If 'adaptability' was truly a salient issue in these women's families, as the circumplex model suggests, then it would emerge from the stories without prompting.

In the second half of the interview I asked the women about their experiences with bulimia in the context of their familial and racial/cultural environments. Open-ended questions asked about how bulimia became a part of their lives, how their families related to each other after bulimia developed, how they experienced their eating disorder as a woman from a particular race/culture, and how they conceptualized their position in the recovery process. I developed many of these questions based on sensitizing concepts drawn from feminist theory, such as gender, race, culture, roles, and power.

### *Interviewing Skills*

As many books on qualitative research methodologies have explored, the skillfulness of the interviewer is an important component of this research that should not be dismissed or minimized by the researcher. Daly (2007) lists seven fundamental skills of interviewing that I consciously strived to utilize throughout data collection, which include beginning the relationship, being attentive to the participant, staying in the present, maintaining naïveté, holding to the interview protocol, monitoring personal engagement with the participant, and maximizing the collaborative potential of the

interview. To *begin the relationship*, I engaged in “small talk” with the participant; we discussed her progress in school or her job, upcoming plans for the weekend, and other miscellaneous topics. This exchange often lasted 5-10 minutes, which conveyed my interest in learning about her as a person, and not just interested in getting my data. I also shared a bit of information about myself as a family therapist who treats individuals and families affected by eating disorders.

For the present study, a major component of *being attentive to the participant* involved protecting her story, particularly when we met in public places such as a coffee shop or park. For many of the women, participation in this study was met with skepticism and concern about how their identity would be protected and their story interpreted. They wanted to meet me in a public place to ensure that their families or friends would not find out about their participation, but they were concerned that nearby patrons may overhear our conversation. Thus, when meeting in a public place, I always arrived early so that I could find a seating area that would afford us some privacy (e.g., a table in the corner, a park bench far from other visitors). During several of the interviews, we paused the interview to move to another table so as to create distance between us and another person(s). In fact, during one interview we switched tables three times so that the participant felt comfortable throughout the entirety of the interview. Many of the women thanked me for being so in tune to the importance of protecting their story.

Another way in which I was attentive to the women was by asking them if they were comfortable with me using the words “eating disorder” and “bulimia” throughout the interview. This developed after completing the first interview; I asked Jessica (C)

about her experience with the interview and she shared how uncomfortable she felt with me using those two words so often throughout the interview.

I don't like the word 'bulimia.' I would rather be anorexic, or the term 'eating disorder' I hate that word so much. So you constantly saying it, it was weird...it's just one of those things I hate being labeled as that. I mean, I know I am but if someone's going to ask me I just tell them I have an eating disorder. And I cut out the whole laxative thing. I'll tell them I throw up but I'm not going to tell anyone that I... I just don't like when people, I mean obviously I contacted you so I'm not, I've gotten over that one but I still don't like that... I used to hate it in treatment. I used to hate seeing it on paper. But now in treatment I'm not afraid to say it but to the outside world I have an eating disorder. They don't know that I have. I just let them think whatever they want because I'd rather them think, I think it's the stigma.<sup>6</sup>

Clearly, the stigma of being labeled 'bulimic' was very painful for this woman. In consideration of this feedback, I asked the remaining 32 participants if they felt comfortable with me using those words. The majority of them affirmed that it did not bother them, however a few gave vague answers, such as "Um, I guess it's okay." In the event that I was given a vague answer, I was purposefully mindful of not using those stigmatizing words and instead asked about their "issue" or the time when "all of this" was going on. After employing this strategy, I received no other feedback about the participants' discomfort with my choice of words.

In an effort to *stay in the moment*, I purposefully scheduled the interviews during days when I had no time constraints and was able to fully participate in the experience. Since there is no way of knowing how long somebody will want to talk, it was imperative for me to allot several hours of time so that I could focus on her story and not on my watch. As a result, many of the interviews were conducted in the evening and on weekends.

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<sup>6</sup> In an effort to condense the length of this paper, all block quotes are formatted with single spacing, rather than following APA guidelines that require double spacing.

To help me *maintain naïveté*, I often “checked in” with the women to ensure that I was interpreting their stories accurately. For example, after Samantha’s (A) lengthy description of how she decidedly refused to let her eating disorder take over her life, I summarized, “So, I’m hearing, and tell me if this is accurate, that after this problem kind of developed you decided that you were going to take control and not...” The woman proceeded to complete the sentence with “...not let it take control of me.” This short exchange allowed for me to verify that what was I hearing was actually what she wanted me to hear. Furthermore, verifying participants’ stories helped me to avoid acting as though what they were saying was obvious, or that I completely understood their experiences. I wanted to convey to the participants that their contribution was unique, captivating, and important.

*Holding to the interview protocol* proved to be the most challenging of these skills, as many of the women wanted to jump right into their story of bulimia without first setting the context in which they developed. There were several interviews in which I would ask them to first please describe their family, and an hour later I had a complete story of her struggle with bulimia and very little information about her family structure or community context. While this information was not collected in a way that I had originally planned, I felt it was important to allow the participants to naturally share their stories in a way that made sense to them, rather than be confined by the structure of my protocol. Thus, after hearing her story of bulimia, I would gently bring her back to the first section in which she described her childhood context. In spite of not always being able to hold firmly to the order of the interview protocol, I was successful in acquiring all of the information sought after in the interview.

To ensure that I *monitored my personal engagement with the participants* so as to remain as neutral as possible, I maintained an *etic* perspective, which allowed me to remain outside of this particular culture so that I could analyze the similarities and differences in the data. Because I have not personally struggled with an eating disorder or supported a friend or family member through their struggle with this illness, I am already considered an “outsider” to this culture. This position affords me the curiosity to understand what the experience is like to have an eating disorder, and not assume what someone is experiencing simply based on my own experiences. This is in sharp contrast to the *emic* perspective, which allows the researcher to intimately share in the life and activities of the participants and their environments (Patton, 2002). Researchers who have experienced their own eating disorder serve as a good example of someone working from this “insider” perspective because they know about this experience much more intimately than people who have never had an eating disorder, and they may be able to connect with their interviewees more quickly simply based on this common experience they share.

It is useful to note, however, that I do not consider myself a true “outsider” with little understanding of the experience. Since 2003, when I began providing therapy to people with eating disorders and making this area my focus of research, I do have a better understanding of what this experience is like compared to someone who has not been immersed in this topic. Thus, while I will always be an “outsider” because of my lack of experience with an eating disorder, I share some “insider” knowledge because of my ongoing commitment to understanding this experience.

To *maximize the collaborative potential of the interview*, I responded to their stories with empathic neutrality, which is a position of understanding and caring that is

free of judgment, while also providing support and recognition responses (e.g., “Thank you,” “That is so helpful”) throughout the interview (Patton, 2002). Additionally, as will be discussed later, I encouraged the women to provide feedback and pose questions to me after reading a draft of the results section. Not only was this member check conducted for the purposes of ensuring sound qualitative research, but also to ensure that the women felt a sense of pride and ownership in this process.

An important component of this research project to consider is the notion of cross-cultural interviews. In the present study, women of various racial groups who *have* had an eating disorder were interviewed by me, a Caucasian researcher who has *not* had an eating disorder. According to Zinn (1979), it was a popular view among some African American scholars in the 1960s and 70s that Caucasians should not conduct research in African American communities because these “outsiders” could not identify or truly understand the culture like an “insider” (someone of the same racial/cultural background). It was doubted that the cultural essence of participants’ stories and data would be understood or accurately presented by the researchers. However, Zinn (1979) goes on to note that other scholars recognize the invaluable utility of an outsider’s etic, not-knowing stance when working with participants of diverse racial backgrounds. For example, while conducting a cross-cultural interview with Wanda (A) she shared with me about the cultural stigma of having an eating disorder, “That’s something other people. We don’t do that.” As a Caucasian researcher, I immediately wondered if by “we” she meant just African Americans or all minorities, in general. So, I asked her, “‘We’ as in African Americans?” She affirmed, “Exactly.” As a Caucasian researcher working with women of diverse racial backgrounds, I worked diligently to remain very mindful of my

outsider position during the interviews by asking participants to elaborate when their discussions of phenomena lacked descriptive detail that may be hidden in simple “You know” responses or vague generalizations. For Michelle (A), my interest in these descriptive details and acknowledgement of culture-specific struggles related to having bulimia was conveyed in her summary of the interview experience, “You are the first person that I’ve talked to about this in my life that, like, understands.”

### *Privacy and Ethical Issues*

All efforts were made to protect the privacy of the participants and their families, as well as to maintain confidentiality of identifiable information. I assigned a five-digit code to each participant’s data in lieu of her name, and I kept all paperwork with their names and other identifying information separate from the raw data. All data and paperwork associated with this study were kept in a locked file cabinet in my University office, to which only I had access. Additionally, all participants chose or were assigned a pseudonym for the purposes of writing and presenting the results to the public.

As Patton (2002) notes, interviewers need an ethical framework for dealing with issues that may unexpectedly arise before, during, or after an interview. Since this study explored women’s struggles with bulimia in the context of their familial relationships and not all of the women were likely to have fully recovered from their eating disorder, there was the potential for emotional hardship if the interview questions evoked painful memories or feelings, and the chance that the women may have sought therapeutic advice from me during the interview (given their understanding that I am a therapist). In the event that a participant expressed discontent due to participating in the interview or sought help from me for her eating disorder, I was prepared to refer her to an online



treatment referral source, [www.edreferral.com](http://www.edreferral.com), that can provide information about eating disorders as well as state-by-state referrals for therapists specializing in the treatment of eating disorders; I shared this information with a few of the women. Furthermore, clients were made aware of my duty to report/warn should I learn of any past or present abuse of a child or disabled adult, expressed suicidal ideations, or expressed intent to harm someone else. Fortunately, of the women who spoke about childhood abuse, all informed me that the appropriate authorities had been notified.

### Data Analysis Procedures

Qualitative data are subject to both content and thematic analyses at all stages of the research, from the time of the first interview to the discussion of findings and implications. According to Daly (2007), there are three main stages of coding and analysis in grounded theory, which include open coding, axial coding, and selective coding. In an effort to organize the data in a way that would allow me to move smoothly through these stages of analysis, I entered all of my raw data (e.g. transcribed interviews, personal memos and reflections) into the qualitative data management software NVivo, version N7. This program allowed me to organize the data and develop and modify an electronic codebook throughout the ongoing analyses (see Appendix H).

The first stage of analysis, *open coding*, involves breaking down the data into manageable segments through line-by-line analysis of each transcription and creating concepts. Open coding is a liberal process of openly applying labels and codes (i.e., ‘naming’) to data segments that are meaningful in some way (Strauss & Corbin, 1990). During this process, I was sifting through the data for salient words, phrases, sentences, concepts, and ideas that were repeatedly used by participants. For example, many of the

women talked about their relationships with their mothers as being emotionally distant and lonely. These segments of interview were coded as one specific concept, “Mother-daughter relationship.” During this stage special attention was also given to the different experiences of minority women. For example, many of the women talked about feeling caught in the middle of their racial culture and the dominant Anglo culture. Even though each story was a bit different in how this bicultural context affected the women, all of these stories were coded as one specific concept, “Bicultural context.” A subsequent stage of coding allowed me to identify the subtle differences in their experiences.

The second stage of analysis, making linkages in the data, is often referred to as *axial coding*, which is a reassembly of the data after completing the open coding process (Daly, 2007; LaRossa, 2005). This stage of analysis involves looking at emergent relationships within and between the categories created in stage one. As a result, several categories that are somewhat similar (have the same core “axis”) may be collapsed into a larger, more abstract category with new properties and dimensions. For example, during stage one of coding, the categories “Mother-daughter relationship” and “Sibling relationship” emerged as important concepts in my understanding of the women’s experiences with bulimia. In an attempt to examine the relationship between these concepts, I created a higher-order concept, “Strained family relationships” to address a key issue in the women’s stories, in which they talked about how these relationships really influenced their experiences of bulimia. I then tested this new, higher-order concept to see if the data truly embodied this category, resulting in a constant vacillation between the two stages of coding. Eventually, organizing the data around racial/cultural and familial concepts provided a sound framework for the data.

Comparative analysis, in which concepts are compared in an effort to construct categories, serves as the primary way in which the data are organized and synthesized into meaningful groups during stage two of analysis (Patton, 2002). Daly (2007) warns researchers that this is the stage where the analyses are the most complex due to the potentially overwhelming number of categories and related codes that are emerging. However, this complexity speaks to the wide range of theoretical possibilities, and so it is important to allow the numerous categories to emerge. After completing the open coding process and then embarking on the axial coding phase, I felt particularly overwhelmed by the amount of data available for use and the number of separate nodes that were created during the preliminary analyses. Early in this process, I recorded a personal memo about this experience, “I’m feeling unsure of my ability to appropriately organize, interpret, and report all of this data. There are so many issues I want (need?) to address and I’m just not sure where to begin. I’m hoping all of these textbooks are correct in their prediction that this will begin to make sense...” Fortunately, as I spent more time with the data reading (and re-reading) the interviews and creating open codes, emergent concepts did start to make sense and I began to feel more in control of the data and the analysis/interpretation process.

The third stage of analysis, creating the theoretical story line, involves integrating and refining the theory through the analyses of participants’ stories (Daly, 2007). Using *selective coding*, data are interpreted and carefully chosen to help tell a “story” that integrates the categories created through open and axial coding. At this point, the researcher seeks to weave together the data with the theories, a process known as abduction, to determine the core categories that will serve as the “narrative spine” for the

story (Daly, 2007). For this study, sensitizing concepts drawn from feminist and family systems theories were used to organize the data into a theoretically sound framework. Ultimately, emergent themes were organized into one of two categories: common themes that emerged with similar frequency from all three racial groups, and common themes that were more specific to one or two racial/cultural groups. Then, within each of these categories, factors at the sociocultural, familial, and individual levels were explored. This multi-level classification allowed for the racial/cultural (feminist theory) and familial (family systems theory) factors to be explored in a way that provided a more holistic construction of the women's stories.

It is important to note that movement through these stages of coding and analysis was not linear or consecutive. As new abstract categories were created during axial coding, it was necessary to then return to open coding so as to comb through the interviews with this new code in mind. Furthermore, as the narrative spine of this project was created during the selective coding phase, I returned to open and axial coding at times to verify or modify the construction of categories of which this story was comprised. All of this was done in an effort to organize the data in a meaningful way and ensure that my interpretations were representative of the women's stories. Strauss and Corbin (1990) highlight the significance and utility of researchers moving back and forth between stages as data collection and analysis simultaneously occur so as to modify and polish codes and categories in an effort to capture the authentic story emerging from the data.

## Trustworthiness and Authenticity of Qualitative Analysis

The trustworthiness and authenticity of qualitative research are determined by a variety of methodological and analytical components throughout the research process. Unlike quantitative research, which focuses on validity, reliability, and objectivity of the analyses, the trustworthiness of qualitative research is measured by its credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). To ensure that this qualitative study was trustworthy and authentic, a variety of techniques were used which are explored in more detail below.

### *Credibility*

The *credibility* of a qualitative study refers to how well the project is designed and executed in accordance with the relevant qualitative methodologies, as well as how accurately the participants' stories and meanings are portrayed (Daly, 2007; Lincoln & Guba, 1985). Credibility is sometimes likened to the internal validity of quantitative studies, which refers to a study's ability to show a cause-and-effect relationship between the independent and dependent variables. According to Daly (2007), a study's credibility is strengthened by the theoretical frameworks guiding specific lines of inquiry, the ways in which participants are selected, how data are generated, and the extent to which the researcher is involved in the field. The credibility of procedures and outcomes of this study were strengthened by the use of peer review and debriefing, triangulation, and member checking.

*Peer review and debriefing* is an important technique that allows the researcher to receive constructive criticism and feedback about her/his qualitative work in an environment that is supportive and non-threatening (Lincoln & Guba, 1985). Colleagues'

thoughts, suggestions, and questions about one's qualitative work are similar to the quantitative concept of inter-rater reliability. During the development of this study, I participated in a monthly qualitative research group made up of several colleagues who were also conducting independent qualitative research. Meetings were used to talk about our specific projects (e.g. ask questions, receive feedback), as well as to explore topical and methodological areas of qualitative research that are new or interesting to the group. During the analysis of data, I asked a member of this group to read some of the interview transcripts and then review the categories and emerging theoretical framework that I had developed. I specifically requested feedback about how well the categories represented the data and related to each other. Additionally, I also arranged three meetings throughout the duration of this project with my four undergraduate transcribers to hear from them which issues or themes they considered important, and to share with them my thoughts on emergent themes. Input from both the research group and the transcribers corroborated many of the identified findings, while also helping me to clarify the concepts and develop specific language to describe the phenomena.

*Triangulation* involves utilizing a variety of data collection techniques and drawing from a variety of participants with the purpose of substantiating the findings and gaining a more holistic perspective of the emergent concepts (Daly, 2007; Patton, 2002). The four types of triangulation in qualitative research are data, investigator, theoretical, and methodological. For the purposes of this study, I used both data and theoretical triangulation. Data triangulation refers to the use of multiple data sources throughout the study. As previously noted, in addition to the one-on-one interviews with participants, I took notes during and after each interview to capture my thoughts, questions, and

reactions to the interview process, as well as important points made by the participants. These notes were considered an important source of supplemental data because they included qualitative information that is not necessarily captured during the actual interview (and subsequent transcription). For example, about halfway through the interviews I wrote a memo that read:

There's an interesting juxtaposition of girls doing everything they could to seem as though they hated their parents and wanted nothing to do with them, but then on the inside they were secretly hoping that their parents would notice the eating disorder clues, that they would notice something was wrong. How can we as therapists help parents see through this façade of anger, hatred, and distance? It must be so hard for them to believe that their kids really do want them when their actions say something totally different.

Memos such as these were used to triangulate the interview data and help me reach a level of saturation, meaning that no new themes emerge from the whole data set (interviews and memo notes).

I also used theoretical triangulation, which refers to the use of multiple theoretical perspectives to analyze the data from a modified grounded theory approach. As previously mentioned, the combination of feminist and family systems theories provided a more holistic lens through which the women's stories were analyzed, than had I only used one of these theories.

*Member checking* allows the participants to review the researcher's analyses and interpretations of the data and to provide their reactions and suggestions for improvement (Patton, 2002). In this study, I invited all of the participants to read through a draft of the results and provide feedback via email so that their ideas could be considered in light of the findings and discussion. To date, over one-third of the participants have replied with comments, and none of them expressed concerns about the ways in which they or their

families were represented. Only one woman provided clarification of a few quotes (e.g., take out the word “like,” rephrase concept in more eloquent terms), and the remaining participants provided positive feedback. For example, Amber (C) wrote:

From someone suffering from bulimia, it is interesting to hear what other women with similar experiences say. Also, women that are different – to hear what it is like for them. Makes you not feel alone...thank you for your interest in our disorder.

Sophia (L) replied, “I am currently taking introductory courses in Psychology and Sociology so seeing the sociocultural application was particularly interesting...thank you for devoting so much time to what is often a taboo cause.” Cara (C) also wrote, “It was really cool to see how you put together people’s stories and how well you understand this disorder. It was interesting and enlightening to read your paper and I hope you are really proud of it.” Madison (L) shared, “There are so many things that make me shudder, it’s hard to read about other people who have/had the same problem as mine, but I’m glad they are sharing their own stories to help other people.” Finally, Kayla (L) wrote, “It was a very interesting read...thank you so much for your devotion to this issue.”

### *Transferability*

*Transferability*, or fittingness, refers to the degree to which the qualitative findings can be generalized to another situation or setting under similar, but not identical, conditions (Patton, 2002). This naturalistic term is often paralleled with the quantitative concept of external validity, which is the extent to which the results can be generalized to the larger population. According to Lincoln and Guba (1985), the degree to which findings may be applied to other contexts is heavily reliant on the researcher’s field notes, which should be full of “thick description” (Patton, 2002, p. 437). Descriptions that are



thick, deep, and rich take the reader into the setting being described, the experiences of the researcher while in that setting, and the outcomes of that experience. Patton (2002) notes the importance of separating description from interpretation, in which descriptions should not explain or answer “why,” but should simply portray the experience. In this study, I recorded field notes to create thick, rich descriptions of the interview experiences so that readers would be able to decide how well these findings may transfer to other contexts.

### *Dependability*

*Dependability* is the qualitative equivalent of the quantitative research term, reliability, which refers to how well a study and its findings can be replicated. Since the hallmark of qualitative research design is flexibility and allowance for findings to emerge within the context of interactions between researchers and participants, ensuring replicability is nearly impossible and not necessarily a goal of qualitative research. Thus, Lincoln and Guba (1985) developed the concept of *inquiry auditing*, in which the process and product of the qualitative research is tracked and examined for consistency by a third party. The researcher is responsible for creating an audit trail, which may include recorded materials, interview transcripts, interview guides, lists of interviewees, lists of created categories, field notes, and written guidelines of research procedures (Schwandt, 1997). To ensure dependability in this study, I kept a written record of all products and processes related to the research. Also, I recorded ongoing consultations with both the dissertation chair, Dr. Leslie, and a qualitative research group made up of colleagues who were also conducting qualitative research so that an “audit” of the materials (e.g.

interview transcripts, personal memoirs) could be conducted to compare the findings to ensure that the process and product of the research is sound and consistent.

### *Confirmability*

*Confirmability* is concerned with how well the qualitative findings and interpretations are steeped in the data, and “not merely figments of the inquirer’s imagination” (Schwandt, 1997, p. 164). Similar to the quantitative concept of objectivity, interpretations of qualitative data should be as neutral as possible in spite of researchers’ values inherently guiding studies. To avoid the dichotomous argument of objective vs. subjective, Patton (2002) encourages qualitative researchers to strive for “empathic neutrality” (p. 50) in which the researcher may be empathic toward the participant but remains neutral toward the findings. Similar to the way in which dependability can be accounted for in a qualitative study, Lincoln and Guba (1985) suggest that qualitative researchers also seek a *confirmability audit*, in which a third party attests to the neutrality of the research interpretations based on an audit trail consisting of raw data, process and analysis notes and memos, personal notes, and preliminary developmental information. This is different from an inquiry audit, in that this audit trail seeks to demonstrate the researcher’s neutrality in reporting the findings, rather than the other audit trail which seeks to track the analysis of data for overall consistency. In an effort to verify the neutrality of interpretations for this study, I developed and maintained a confirmability audit trail, which consisted of raw data; theoretical memos (notes about the formulation and evolution of theory development); field notes with thick, rich descriptions; and a code book documenting the coding scheme as it is created and refined.

## Personal Biography

As the primary “tool” of the current study, my personal experiences and interests have certainly influenced how and why I pursued this specific topic of research. Qualitative research, particularly when guided by a feminist framework, encourages researchers to be transparent in sharing our personal biographies for the purpose of helping others understand how the interpretation and presentation of results may have been influenced by our own assumptions, values, and backgrounds (Daly, 2007). As a Caucasian woman born and raised in the U.S., I grew up in an image-obsessed culture. This experience was punctuated during my childhood and adolescent years when I was teased for being overweight and not conforming to the Caucasian culture’s standards of beauty. While I am grateful for never having experienced an eating disorder, I will forever remember the days when I truly believed that if only I was thinner, then surely my life would be better. However, I will also remember the countless hours spent talking with my mom about the daily harassments I endured at school, and her dedication to comforting me and assuring me that one day everything would be okay.

During my time in graduate school, I haphazardly began to work with women affected by eating disorders, and it became crystal clear to me that these disorders not only embodied my interest in physical and mental health, but also captured the pain, deception, and embarrassment related to their bodies that I, too, had experienced at one point in my life. Since then, I have dedicated my professional pursuits to understanding these illnesses and trying to help other people break free from the emotional prisons these illnesses can create.

My interest in family dynamics is directly related to my career as a Couple and Family Therapist. I am eager to learn more about how family environments shape

people's experiences with eating disorders, and I always strive to do this in a way that is respectful and collaborative. Thus, a qualitative approach to this study afforded me the opportunity to hear how women perceived their families and described these experiences with respect to their eating disorder.

My interest in racial and cultural differences blossomed after moving cross-country for graduate school and realizing that a very diverse and colorful world existed outside of my predominantly Caucasian suburban neighborhood in the Southwest. Since formally learning about other cultures in my courses and working with clients from diverse backgrounds, I feel compelled to bring this knowledge into the dominant discourse on eating disorders. I hope that this study is only the beginning of my endeavors.

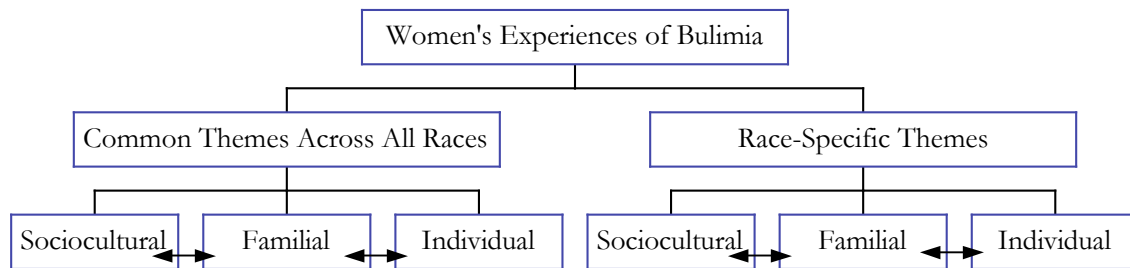
## CHAPTER 4: RESULTS

### Overview of Results Framework

A modified grounded theory model for how African American, Latina, and Caucasian women understand their experiences with bulimia through the lenses of their familial and racial/cultural contexts was developed using interview data collected from 33 women (ages 18-30) who had or have bulimia and who lived with at least one parent during the time of their illness. This chapter presents thick, rich descriptions of these women's experiences with bulimia and findings are organized around a cultural framework of the women's lives. The first half of the narrative paints the settings in which the women developed (prior to bulimia), including their family structure, neighborhoods and schools, and cultural values related to body image and gender roles. This section addresses each racial group independently in an effort to punctuate the cultural variations in the women's childhood experiences, and to provide the reader with a holistic understanding of each group within the context of the other two groups. The second half of the narrative explores emergent themes related to how the women described their eating disorders; this section is organized into two main categories. First, many common themes emerged from the women's stories across all three racial groups, such as strained family communication and intense focus on body image. While not all of these themes emerged with the same frequency, they were not exclusive to any particular racial/cultural group. Second, some themes were clearly specific to just one or two racial groups and not addressed by the other group(s), such as minority women feeling caught in a "bicultural context" with respect to their eating disorders. Figure 1 provides a graphic representation of how the major findings were organized. The bidirectional areas between

the sociocultural, familial, and individual levels represent the inherent overlap of themes across these three levels, such that sociocultural issues (e.g., bicultural context) were also experienced by the women at familial and/or individual levels and vice versa.

Figure 1: Organization of Major Findings



This results framework was developed based upon the emergent categories identified during the axial and selective coding of data analysis. While a *pure* grounded theory approach would strictly rely on emergent themes and concepts to generate the story, this project relied on a *modified* grounded theory approach in which previous research and current theoretical frameworks indicated some important and relevant concepts prior to beginning data collection and analyses. For example, because the present study aims to understand the experiences of bulimia with women from diverse racial and cultural backgrounds, I planned for the narrative to explore the similarities and differences in African American, Latina, and Caucasian women's experiences with bulimia prior to even beginning the interviews. Similarly, since this study seeks to better understand racially diverse families' experiences with an eating disorder, emphasis on family relationships and family communication was expected to be included in this narrative. Yet in spite of this loosely premeditated framework for conceptualizing the data, many salient themes naturally emerged that were not necessarily expected. For

example, after multiple assessments of the data, describing the women's cultural contexts with respect to childhood experiences helped to contextually ground the story.

Additionally, specific themes related to birth order, mother-daughter relationships, and "acting white" organically emerged from the data and are important contributions to better understanding the women's experiences with bulimia.

Poignant quotations from the participating women provide supportive evidence for the results and further illustrate the relevance of salient themes. All of the women's names have been changed to protect their identities, as well as their families' identities. First-name pseudonyms are used to identify each woman, and when not stated in the text her race (A = African American, L = Latina, C = Caucasian) is included in parentheses after her name. When relevant, additional identifying information is provided, such as a woman's age, family structure, or country of origin.

It is important to note that this project is the initial attempt to extrapolate many of the important concepts steeped in the data, and it is impossible to touch on all of the important issues at one time and in one document. Thus, ongoing analyses over time will provide opportunities to evaluate and re-evaluate the data from new perspectives, with the ultimate goal of developing a holistic and broad understanding of the women's experiences with bulimia, particularly focusing on the cultural themes of their stories.

Finally, the use of the terms 'race' and 'culture' are woven throughout this chapter, and the choice of which word to use is intentional. When speaking about a participant's visible traits, I refer to her *race* (U.S. Census Bureau, 2001); when referring to her beliefs and lifestyle qualities, I speak of her *culture* (Swidler, 1986). At times, both race and culture are appropriate terms, in which I refer to her *racial/cultural* experience.

## Cultural Contexts of Participants

This section provides rich descriptions of the women's environments prior to the development of their eating disorders. Contextual factors, including those at the sociocultural, community, and familial levels are included to provide the reader with a more holistic understanding of the participants' backgrounds. While some issues, such as family relationships, are inextricably linked to the women's narratives of their experiences with bulimia, this section simply describes the context in which the women developed. The next section will then provide richer detail about how some of these variables are specifically related to the women's understandings of their illnesses. So as to capture the cultural flavors of these women's ecological contexts, the descriptions in this section are classified by race.

### *African American Women*

The community contexts in which the African American women were raised were somewhat varied with respect to racial/cultural diversity and socioeconomic status. Over one-third of the women grew up in predominantly white neighborhoods and went to school with almost all white students. For some of these women, being the "token" minority was an unforgettable experience. Wanda recalled being "the only black family on [her] street" and once she enrolled in gifted classes at school, she was "the only black person...in the class of maybe like 20 or 25." Bianca also recalled being "the only black student" all through her elementary school years. Additionally, Lauren vividly recalled a conversation with her mom about a year after they moved into an all-white neighborhood, when more and more African American families were moving in and all their white neighbors were quickly moving out:



I would say, ‘Hey, why are people moving out? What’s going on? Why aren’t we moving?’ And they’d be like, ‘Um, no, we’re here to stay. They don’t want to be around us.’ And you could tell...we were from, it was a small suburb so it was like if you see somebody you acknowledge them, you say, ‘Hi, how are you doing?’...I could say, ‘Hi’ but white people wouldn’t respond.

She went on to describe this phenomenon as “white flight,” in which white people flee neighborhoods once families of color begin moving in. Interestingly, these experiences of feeling unwanted or rejected by white neighbors were corroborated by one of the white participant’s recount of how her all-white neighborhood reacted when an African American family joined the community, “All of the people around us were white but we had a black family move in and that was a whole big deal...it wasn’t that people weren’t very pleased it was just different...I’m not a racist or anything it’s just how...” Jessica never did complete her sentence of how it “just is” to have a black family move in nearby, but women like Lauren certainly picked up on this unspoken discomfort between the races.

The remaining two-thirds of the African American women grew up in diverse communities (45%) or all-black communities (18%). Unlike the women who lived in all-white neighborhoods and noted the drawbacks of these communities, none of the women living in diverse communities spoke to the pros or cons of this environment.

The majority (82%) of the African American women grew up in middle-class neighborhoods, while 18% of the women lived in upper-class communities and 9% of the women grew up in a lower-socioeconomic community. The total of these percentages surpasses 100% because Lynn lived in an upper-class neighborhood during her early childhood years, but then after her parents’ divorce she moved to a middle-class community with her mom and brothers. None of the women, including Debra who grew

up amidst section 8 housing, spoke of ever wanting something they could not have due to a lack of financial resources; in fact, many of the women felt as though they were provided most everything they desired throughout their childhoods.

The types of schools in which the African American women attended were, for the most part, average schools scattered throughout the country. All of the women attended public schools, except for Michelle who recalled being the “spoiled girl” enrolled in private school from kindergarten through tenth grade. She was then forced to enroll in public school for the remaining two years of high school because her private school did not offer those grades. This difficult transition, in which she discovered for the first time that she could “skip school,” emerged as an important component of her understanding of bulimia. In sharp contrast, Nicole attended a poorly funded public school in Lansing, Michigan that made it difficult to even focus on academic success due to the school’s dilapidated and dangerous environment, “There was parts we couldn’t walk in; they had caution tape around the whole time, not because they were about to work on it, but for like years.” In spite of these two extreme cases, the majority of women attended average public schools that provided a sound education and adequately funded services.

While growing up in these communities, all of the African American women received specific, yet often unspoken, messages about how they should look. With respect to body image, the women overwhelmingly learned that “voluptuous and curvy” bodies were most valued within their cultural community; only 18% of the women believed that thin bodies were most attractive. However, while they understood that it was acceptable to have some “meat on their bones” and to have a “bubble butt,” they also

clarified that they still wanted to be thin, just not to the same degree as Caucasian women. For example, Nicole noted the difference in ideal body size between the Caucasian and African American cultures, “Like skinny to them and skinny to us was still like five sizes different. I said I couldn’t even imagine trying to be a size three; I’m like trying to be a size seven.” Some of the women, like Lauren, also specified that small stomachs and larger butts are the most attractive body form in the African American culture, “It doesn’t matter how big your butt gets, as long as your waist is smaller. That’s good.”

While all of the African American women were absorbing these messages about body shape, and were seemingly satisfied with these messages, one-third of them were being cruelly teased at school for being “fat,” “chubby,” “large,” or “heavy” as young children. For instance, Ifeoma recalled the constant teasing she endured for her bigger body:

I guess I didn’t realize how big I was. Maybe I didn’t look in the mirror a lot. I don’t know. So that’s when kids started teasing me a lot...there was a lot of, just everyone, mostly kids, calling me names and everything.

Additionally, Debra, who has an identical twin sister, shamefully recalled how the kids at her school were able to tell the sisters apart:

I had a double chin until 8<sup>th</sup> grade and it was obvious this double chin and I just remember when you cut up your pictures and you give your friends your pictures after picture day and everyone could see my double chin and they’d be like, “How come [your sister] doesn’t have a double chin but you have a double chin?” And that’s how people used to tell us apart. I was always the fatter one.

Interestingly, both Ifeoma and Debra grew up and attended school in racially diverse communities where the acceptance of larger bodies was presumably more present than in

an all-white neighborhood, and yet the children still teased them for not having the right body size.

In addition to messages about body image that the African American women received, they also were privy to culture-specific messages about how they should behave as young, black women. Bianca and Ifeoma, the only first-generation African Americans in this sample whose parents recently immigrated (from Congo and Nigeria, respectively) spoke about the pressure they felt to become a good matriarch, wife, and mother to their families, just as their mothers and grandmothers had done. For example, in spite of the fact that Bianca had always lived in the U.S. and adopted more egalitarian gender expectations, her mother still preached that “the woman is supposed to do all the cooking and the cleaning” while also maintaining a full-time job and satisfying her husband. Similarly, Ifeoma’s parents made it very clear to her that she needed to be considering and preparing for marriage, preferably to a Nigerian man. Samantha also spoke of a very important cultural message aimed at African Americans, in which society as a whole does not really provide “room for weakness” for this population:

The major message that I did receive that I still receive is like I said before, especially when you live in the inner city, you’re not respected. There are low standards held and you know, you’re expected to be one thing but the truth is you have to prove to be another...a lot of young Black African American females, they portray negativity and they don’t really want a lot out of life, or they don’t show that they want a lot out of life so I feel again that it is my duty to show not just myself but the world otherwise because I feel like there are too many misconceptions...I just feel like it’s my duty to be different. I’ve always felt different. I feel like I have to be different because if I won’t, who else will?

The women’s explorations of how they sought to strike a balance between the cultural expectations of their racial culture and the expectations of the larger dominant Anglo

culture is described at length later in this chapter as the women describe their experiences with bulimia.

In an attempt to understand how the participants learned about eating disorders and specific behaviors related to their illnesses, the women were asked, “Do you ever recall hearing anything about eating disorders?” Approximately half of the African American women had learned about eating disorders either from a television show (e.g., talk show, made-for-TV movie, news story) or other girls at school who actually had an eating disorder. Interestingly, of the three women who knew of a girl at school with an actual eating disorder, one went to an all-white school, while the other two went to diverse schools with predominantly racial minority students. Thus, the notion that perhaps these African American women “learned” of these behaviors via Caucasian girls, who are thought to be more prone to eating disorders, may not necessarily be true. The other half of the African American women never learned about these illnesses and just informally “discovered” the behaviors on their own.

The familial environments in which the African American participants were raised represented a diverse cross-section. When asked to define “family” and identify the “key players” in their narratives, all of the African American women identified their moms, dads, and siblings; 55% of the women also identified grandparents, aunts, god-relatives, their own child and/or ex-boyfriends who played a significant role in their lives. Most notably, when describing their family structures, 46% of the women described a distant relationship with their fathers, in which he was not living in the home during some portion of her childhood. Forty percent of these women never actually lived with their dads, and 60% of them experienced their parents’ divorces (at ages 3, 9, and 12), which

then prompted their fathers to live in separate residences. All of the fathers remained living in the same city, but maintained sparse contact with their daughters, often only calling or visiting on holidays and birthdays. This physical and emotional distance in the father-daughter relationship as it relates to the women's experiences with the bulimia is discussed later in this chapter.

Levels of education and career paths among the African American women and their families also varied greatly. At the time of the interview, nearly half of the women had completed college and were working; additionally, 9% had completed high school but not started college, 27% were currently in college, 9% were enrolled in a graduate school program, and 9% had earned a graduate degree and were working. Furthermore, their parents' careers varied, ranging from manual labor positions (e.g., cook, grocery store clerk) to service providers (e.g., social worker, nurse, teacher) to white-collar professionals (e.g., engineer, microbiologist, insurance sales). Additionally, 18% of the women's mothers stayed at home with the family during their daughters' childhood years.

When asked about the general family environment growing up, interestingly *all* of the African American women noted very positive aspects of their home environments. In contrast to much of the family literature (with predominantly Caucasian samples) suggesting that families affected by eating disorders are very prone to conflict and chaos with few positive interactions, the African American women did not describe this type of environment. Rather, they described their families as "balanced," "nurturing," and "easygoing." Michelle even noted that her family, in which her dad served in the military

while her mom stayed home to raise the children, was often likened to one of television's loved families, the Huxtables, from *The Cosby Show*.

However, about half of these favorable descriptions were also coupled with women's memories of very distinct stressors that seethed below this calm and loving family context. Pressure from parents to be the perfect child, parents' substance abuse, and parents' relationship conflict were cited as taxing issues that took away from the family's otherwise pleasant environment. Nicole captured this dichotomous and precarious home environment, in which daytime brought happiness and serenity to the family, but at nightfall her parents' relationship was stricken by conflict and abuse:

It was really stressful...during the day, everything seemed normal, just regular. It just seemed like every night it would just be chaos. Every night...I do remember them getting really, really loud and I'd hear pots and pans, stuff slamming down. Then I'd get up [from bed]...So I slept with [my mom] every night and even after that I slept with her for like the next two or three years because that was just what we did.

Lynn also recounted the vacillations in her home environment, in which her mother was very responsive and nurturing, while her father's occasional presence riddled the family with abuse and stress:

When we were kids my mom, she was home all the time so my mom did all the things to make us feel like we lived in this fairy tale world where we were loved and we had so much fun and, but at the same time trying to balance being a parent. Our father traveled quite a bit when we were young but when he was there it was always, we'd rather be with our mom than our dad. He was very critical, very harsh. Just very, not a nice person at all.

As these quotes demonstrate, all of the women recounted very positive memories of their childhoods, but stressors within their families also qualified many of the narratives. More specific accounts of the family environments, particularly with respect to parent-child

relationships and family communication, are later explored in-depth as they relate to the African American women's understandings of their experiences with bulimia.

### *Latinas*

The Latina participants grew up in varied communities, particularly with respect to geographic location, racial diversity, and socioeconomic status. Unique to the Latina sample, participants represented seven countries, including Chile, Dominican Republic, Ecuador, Guatemala, Mexico, Peru, and Spain. Also distinctive to this group, half of the women immigrated to the United States; three of the women moved here with their nuclear families during their elementary school years, and two of the women immigrated here alone once they became adults. Many of the women who immigrated recalled the significance of moving to the U.S. and leaving behind the comforts of 'home.' For example, Celestine recalled the trauma of leaving behind her dad in Peru and moving to the U.S. at age 6 with her mom:

All I remember really is that we came, flew here, stayed with family and I thought I was going back, the last time I really saw my dad. And we ended up staying here. So then that was a big change, moving at that age, kind of going through that separation anxiety with my dad and it was, I just couldn't get it right understanding why.

She went on to describe her precarious living situation in the U.S., in which she never had a place to call 'home,' but instead lived with various family members year-to-year while her mom was very transient with both housing and jobs. Fortunately, Celestine often stayed in the same school district, but she remembered the stress of moving to different relatives' houses during the summers between school years. This lack of a "family home base" later influenced her understanding of bulimia. Similarly, Margie immigrated to the U.S. from Ecuador at age 12 with her mom and brother and recounted



the trauma of being thrust into a new culture, “I was scared because I didn’t know the language...I didn’t know nobody here except for my dad.” Although moving to the U.S. allowed Margie to reunite with her father, who had been living here for several years and earning money to bring the family over, she also left behind her protective older brother, who she has not seen since they moved from Ecuador over seven years ago. She recounted:

I always talk on the phone with him... It’s hard for me to have him far away but I mean every time I listen to, we have a song together, we have a song that every time I hear that song I remember him.

Still other immigrant women found their move to be very positive. For example, Mariana emigrated from Guatemala with her parents and sisters at age 7 after they “vacationed” in the U.S. for a few months and decided to stay for the sake of the children’s education.

She recalled how well she was able to acculturate and meet new friends instantly:

I didn’t know any English...and my dad says that I hadn’t even been here 48 hours and I had already made friends with the kids from the neighborhood and they were coming to look for me and knock at the door and ask for me, and my parents were like, “Well, how did she speak to them?” and I don’t remember, I would just talk to them, I don’t know. I was very friendly.

Madison also described her independent decision to emigrate from Mexico, “It was a hard decision but I mean I’m having a really good time.” At the time of the interview, just one year after her move, Madison had already accrued a large group of friends, enrolled in law school, and was enjoying the cultural novelties of America.

The other half of the Latinas, who did not emigrate from a foreign country, were born in the U.S. either as first- or second-generation children (meaning their parents and/or grandparents immigrated). Although these women did not have to endure the disruption of moving from one country to another, they did speak to the cultural gap

between their generation and earlier generations who were born in other countries. For example, Kayla, a first-generation daughter whose mother was born in Ecuador, spoke about the “third parent role” she adopted in an effort to help her parents learn proper English and navigate day-to-day living in America:

We would all sit down, they would just talk about financial stuff or this and that; it was kind of overwhelming at times...they really relied on me for a lot of different things like writing papers or even sending emails...I always felt like I had to help her out in that way so that was kind of like a burden.

Many of the Latinas went on to explore how this expectation to navigate and negotiate two cultures greatly influenced their experiences with bulimia; this emergent theme is more thoroughly explored later in this chapter.

With respect to racial diversity in their communities, 56% of the nine Latinas who grew up in the U. S. lived in diverse communities, 44% grew up in predominantly Caucasian neighborhoods, and 11% lived in a predominantly African American community. Again, the percentages exceed 100% because Celestine, who moved around each year to live with different family members, at times lived in diverse communities and at other times lived in predominantly Caucasian neighborhoods. Two of the women, Madison and Andrea, spent their entire childhoods living in Mexico and Chile, respectively, in which the communities were racially and culturally homogenous.

Interestingly, when asked to describe their neighborhoods, all of the Latinas simply reported on the racial diversity of people, but made little to no mention of racial/cultural tensions among neighbors; this finding was in contrast to the African American women’s reports of feeling unwanted or even feared by their Caucasian neighbors. In fact, Mariana recalled living among families “from all different backgrounds” and talked about how her dad made friends with everyone on their street.

One comment that did stand out, however, was Kayla's description of how her once predominantly white neighborhood had slowly transformed into a community primarily made up of minority neighbors:

It was predominantly white, it was a middle class neighborhood. People were pretty friendly, it was pretty clean...it's just not the same anymore and now there's a lot more Hispanics coming in and I don't know what direction that is going to throw the community into.

She went on to clarify this "direction" as dangerous and of lower socioeconomic status, which eventually compelled her parents to enroll her in private school so as to escape the risks associated with the deteriorating public school system. While her family remained living in this neighborhood, Kayla's distinction between "us" and "them" implied a certain degree of cultural disconnect or divide between her family and other Latino families in the neighborhood.

With respect to socioeconomic status, 64% of the Latinas were raised in middle-class communities, 27% lived in upper-class environments, and 9% grew up in lower-class neighborhoods. Most interestingly, all three of the women who lived in upper-class communities were living in a Latin American country. Madison, who lived with her family in Mexico until age 22, recalled growing up in a wealthy family in which they owned several luxury amenities (e.g., vacation house, collectible cars) and took exotic family vacations to other countries. Additionally, Andrea grew up in Chile where her parents owned a hotel chain and so they all lived in one of the penthouses in the heart of the city. The third participant, Maria, grew up in an upper-middle class environment in the U.S., and then at age 14 her family decided to return to their home country, Dominican Republic. At that point, her family's socioeconomic level was elevated to "upper-class" because the "dollar was at 33 pesos, and at that time, you know, it was

pretty stable.” All of the other women recalled living in middle-class communities, except for Sophia whose large family lived in “lower-income houses” throughout most of her childhood.

Another unique quality of the Latina participants is the diversity in the type of schools they attended as children. A little over half of these women attended public schools, while the other half attended private school for some portion or all of their education; one woman was home-schooled by her mother. Of the five women enrolled in private schools, over half of them were living in their country of origin at the time. Through the American cultural lens, children in private schools are often equated with families of high socioeconomic levels who can afford the luxuries in life, including a private education. However in Latin American countries, attending private school does not necessarily equal upper class status. Andrea, who is originally from Chile and attended private school throughout all of her elementary and secondary years, provided insight into the cultural differences between private school attendance in Latin America versus the U.S.:

In the schools here in the states, where you have private or you have public...even though good people with good money and good salaries will send their kids to the public...that doesn't mean it's bad. In Chile, what it is if you're in a medium, medium-high, or high [income level] you have to go to private school...because the education in a public is not going to be as good as one of such in a private school...my [private] school wasn't a rich kid school, that's for sure.

As this passage illustrates, public school systems in Latin American countries may be significantly more run-down and void of resources than public schools in the U.S., thus making the private school route more appealing, typical, and even expected of Latino families living above the poverty line.

With respect to messages about body image and physical appearance, the majority of the Latinas echoed similar cultural values as the African American women. Two-thirds of the women reported that they wanted to be thin, but not “that thin” or like “stick figures.” Yet, even though their culture values “curvy” and “voluptuous” female bodies, the women were quick to clarify that they still felt pressure to maintain thin bodies with “the perfect butt and the perfect boobs.” Mya, a first-generation Latina whose family emigrated from Mexico, clarified the expectation she felt to strike the desired balance of looking curvy, yet thin:

You wanted to be thin, but you didn’t want to be too thin in the Latino world, in the Mexican world... a normal in the white community, like a 4 or 6, is definitely more acceptable than I think even in the, that’s thin, thin...you would see chubbier sort of women and I guess being thin really wasn’t the norm.

Sophia also felt caught between the expectations to be thin while still having voluptuous curves. At first, she tried to maintain a healthy, curvy figure but felt dissatisfied with her body shape, and so she eventually strived to just be thin, “If I couldn’t be one, I was gonna be the other.”

The remaining third of the Latinas simply wanted to be “skinny.” Maria noted that in the U.S. all of the thin women “were the ones getting all the attention” and so she strived to earn that recognition by controlling her weight. Interestingly, when she moved to Dominican Republic with her family at age 14, she did not feel the same pressure because having “extremely larger hips” was more common and accepted. Similarly, Madison, who grew up in Mexico, received many compliments for her skinny figure, and so she felt pressure to avoid getting “fat,” otherwise she would look “horrible.”

Furthermore, Andrea, who emigrated alone from Chile, noted her country’s “cult to the body,” in which women are expected to do all they can to maintain “skinny, taller, perfect

bodies.” She theorized that this cultural expectation was adopted from Argentina’s culture of beauty, in which women just got “prettier and prettier every day” through regular visits to the gym and their plastic surgeons.

In addition to the omnipresent expectation that Latinas be curvy yet thin, nearly half of them were teased as children for being overweight. Kayla recalled being “the heaviest one in [her] elementary school” and Maria remembers being “made fun of” by other kids because of her weight. Mya tearfully recollected the annual struggle she faced with back-to-school clothes shopping with her mom, “I was like, ‘Oh, nothing is going to fit.’ I just would remember the arguments that my mom and I would have.” Thus, similar to the experiences of the African American women, the ideal body image did not seem to protect many of them from the cruelties of childhood teasing.

In addition to the overwhelming pressure to look beautiful and healthy, some of the Latinas spoke to the culture-specific expectations of women. For example, Sophia noted her culture’s expectation of mothers, “I think there’s still the man of the house, but I think the mom really controls it. It’s kind of like the unspoken, mom controls it.” Mariana, who always had a distant relationship with her mother, shared her culture’s expectation that she be a nurturing and loving caretaker for her family, yet she often questions if that is what she really wants:

When my mom’s really old and she doesn’t have anybody to take care of her, am I going to want to go and take care of her, want to go visit her? Most likely I will because I have to and I should and obviously I care about her, but whether I really want to, it’s just not there and the way I was brought up and what I was taught, that’s wrong. It’s wrong to be that way.

Similarly, Celestine, who immigrated to the U.S. from Peru with her mother, shared her reactions to the Latin culture’s expectations and prescribed gender roles, “[My family]

wanted me to be with somebody, be married, have kids, be settled already...I want to wait until I'm 30 at least.”

When asked if and how they learned about eating disorders, 64% of the Latinas said they had heard of eating disorders in some capacity prior to the development of their own bulimia; this is slightly more than the African American women. Nearly three quarters of these informed women learned about eating disorders either from a class in school and/or via media outlets, such as talks shows, news stories, and public service announcements. The remaining one-quarter of women did not receive any formal education about eating disorders, but did know of people at school who were affected by the illnesses.

The Latinas' definition of “family” mirrored that of the African American women's discussions of their families. All of the Latinas identified their parents and siblings as important family members in their lives, and 55% of them also cited their grandparents (most often their maternal grandmothers), maternal aunts, cousins, step-parents, nieces/nephews, boyfriends, and their own children as key players in their lives. What stood out the most among these women's narratives was the important role of their mothers' extended families, coupled with the sporadic mention of their paternal extended families. For example, Marissa grew up living with both of her parents, her siblings, and her maternal grandmother. She recalled, “My grandmother was very much a part of my growing up...my mother's side is the side that has really influenced, culturally, my perspectives.” Additionally, Jennifer spent her adolescent years living with her maternal grandparents, and Celestine lived with many of her mother's relatives after moving to the U.S. Thus, as these examples illustrate, the matrilineal network in many of these Latina

families was incredibly strong and played a significant, and often positive, role in the women's lives.

Once again, similar to the African American participants, the Latinas were a well-educated group of women who were raised by parents with a variety of careers. At the time of the interview, 45% of the Latina women had completed some college, 27% were college graduates with careers, and 27% were enrolled in graduate school. Over half of the women's parents had white-collar careers, such as doctors, scientists, and business supervisors. The remaining half of their parents were evenly classified as blue-collar workers (e.g., taxi driver, security guard), service providers (e.g., teacher's assistant, baby-sitter), and stay-at-home mothers.

Nearly three-quarters of the Latinas reported growing up in very "happy" and "close-knit" families; the remaining one-quarter of women recalled very negative aspects of their home contexts that overshadowed the positive memories of their childhoods. Favorable memories of the women's childhoods included words and phrases like "very good," "caring," "calm and loving," and "great." This was further substantiated by the women's reports of very healthy and supportive relationships with their parents, siblings, and/or extended family, which is discussed at length later in this chapter.

Among the three women who recounted more adverse conditions at home, they described tension, physical abuse, and emotionally detached parenting as the reasons for why home was not a positive place for them. Mariana remembered wishing that her parents were more loving and emotionally engaged with their children:

One time a friend of my mom, who became really good friends with my mom, came over to the house and she said, "You can just feel the love." No, you can't feel the love. No, you can't. You really can't...It was very routine, very



mechanical. Just very boom boom boom because you had to do it, because you should do it. That type of thing.

Yet, in spite of these few women who yearned for more nurturing home environments, the majority of Latinas described very warm, supportive memories of their family environments, just as so many of their African American counterparts had also done.

### *Caucasian Women*

With respect to the racial/cultural diversity of the communities in which the Caucasian participants' grew up, all but one of them were raised in "mostly" or "all" white neighborhoods. This number is in sharp contrast to less than half of the African American women and Latinas who grew up in overwhelmingly white neighborhoods. However, half of these Caucasian women attended diverse schools, in which they had the opportunity to interact with children from different racial backgrounds. Some of these women attending diverse schools reported that while there was a presence of minority children, the groups remained very segregated by race. For example, Amber remembered, "[The minority kids] really kind of did their own thing. I don't know where their families lived, honestly. I don't know where their neighborhood...yeah, I couldn't even recall." Similarly, Christine recalled, "We did actually have a good number of minorities but it was very segregated, I mean all my friends were Caucasian mostly." In addition, the one woman who was raised in a "mixed" community, made up of half African American and half Caucasian families, described her experiences in this neighborhood as "very difficult" because she felt "awkward and outcast."

With respect to the socioeconomic status of the Caucasian women's neighborhoods, 80% of them grew up in middle class communities and 20% were raised in upper-class neighborhoods; none of them reported living in lower-class communities.

These numbers are fairly consistent with both the African American women and Latinas, in which the majority of women grew up in middle-class communities.

One interesting factor related to the Caucasian women's community contexts is their disproportionate attendance in private schools. In contrast to only 11% of the general U.S. population who attend private school ([www.census.gov](http://www.census.gov)), 64% of the Caucasian sample attended private school. Furthermore, these women accounted for two-thirds of all participants who attended private school in the U.S. (as previously noted, the remaining one-third consisted of a handful of minority women who attended private school in the U.S. and Latinas attending private schools in their countries of origin). Additionally, Page attended a "fantastic magnet high school," which was not a private school but did provide her with a high-quality, specialized education in technology and environmental science. Thus, while three-quarters of the Caucasian women were afforded the opportunity to attend private, specialized schools in the U.S., only 9% of the African American women and 18% of the Latinas grew up in families who were able to provide similar learning experiences for their daughters.

The messages received by the Caucasian women with respect to body image and appearance were overwhelmingly similar across the women's narratives – they *all* used words like "skinny" and "thin" when asked how they were expected to look as a Caucasian woman. For example, Elizabeth recalled the popular girls at her school, "The girls that dated all the good-looking guys were pretty and had good bodies...no one was particularly overweight." Furthermore, Cara commented that she "always felt pressure to be thin." Additionally, Page remembered being a part of "the weaned on MTV generation," in which she succumbed to society's expectation of her to be thin:

It's just like, okay, well I'm white, I'm suburban-bred, urban girl who's supposed to fit into these jeans. I'm supposed to be able to go into Nordstrom and buy these. What do I need to do to get into them?

Many of the Caucasian women felt as though these standards to be thin and beautiful must be met in order "to get the guy, to get the job."

Interestingly, while many of the African American women and Latinas received cultural messages related to gendered expectations of them, only 18% of the Caucasian women noted pressure they felt to fulfill specific gender-based roles. Furthermore, of these two women who did talk about this pressure, both of them felt weighted down by very different expectations, leaving no common gendered expectations throughout these women's narratives. For instance, Amber recalled feeling like she "fell out of the 50s," in which she learned early on that she was expected to marry a "high-power executive" and "do the family thing." In contrast, Anne knew she was "entitled to go to a four-year college" and she was expected to establish a lucrative, professional career. The remaining 82% of the Caucasian women did not expound upon gendered expectations that influenced their pursuits either in or out of school.

With respect to learning about eating disorders, nearly half (45%) of the Caucasian women knew nothing about eating disorders prior to the development of their own illness. The remaining half of the women who were somewhat knowledgeable about eating disorders were evenly split into those who heard of eating disorders through knowing students at their school affected by these illnesses, and those who had a more formal education through short lessons in health class. In spite of the fact that some women were informed about eating disorders at school, none of them felt as though they were able to fully comprehend the severity of the illness at that time, and/or that enough

information was provided by the school. In response to the lack of effective communication about eating disorders in the schools, two of the participants sought to effect change in their high schools. Jessica never learned about eating disorders in school, and so after she began her battle with bulimia, she talked with her high school about providing students a class on eating disorders. The school denied her request because they were afraid that students would “start having them more if they talk about it.” In contrast, Sarah, who “was really fed up that they didn’t talk about it,” was successful in coordinating her high school’s first eating disorder awareness assembly.

The Caucasian women’s family environments primarily consisted of just nuclear members, including their parents and siblings. Only 18% of the women spoke of extended relatives, such as their grandparents and aunts. This finding is in sharp contrast to over half of the African American women and Latinas who included extended family members in their definitions of “family.”

Similar to the African American women and Latinas, the Caucasian participants had achieved notable levels of education. At the time of the interview, 60% of them had completed some college, 20% were college graduates and working, and 20% were enrolled in graduate school. However, in spite of these similar levels of education across the races, the Caucasian women’s parents were far more likely to have esteemed careers than the African American and Latina parents. Over two-thirds of Caucasian parents held prestigious white-collar positions during the participants’ childhood years. For example, some of the parents were engineers, scientists, lawyers, doctors, and political executives. One quarter of the Caucasian parents were teachers, and the remaining 10% of the

parents were stay-at-home moms. None of the Caucasian participants described their parents' as having blue-collar jobs or unskilled labor positions.

In keeping with the trend found in both the African American women's and Latinas' recollections of their familial environments, the overwhelming number (80%) of Caucasian women also described their families in non-negative ways. Interestingly, however, these women were not as eager as their minority counterparts to use very positive terms to describe their families. Rather, they were more likely to use more neutral, subdued words like "decent," "pretty happy," and "average" to describe the overall feel of their familial environments. Elizabeth noted that people in her family "generally got along fine," and Anne recalled that there was "not a lot of yelling." While these women certainly did not emphasize many positive qualities of their home environments, it is important to note that they also did not recount an abundance of negative aspects of the family context.

The remaining 18% of the Caucasian women specifically cited very negative environments with few positive recollections, which was less than the number of Latina women in similar environments. Jessica, the youngest child living with seemingly unhappy parents, recalled her home life:

Well, it wasn't fun. It was just more, it was so off and on, like one minute we'd be this chipper, cheery family and then the next minute something would blow up and you'd want to go hide in your room because mom is on the rampage...me and my brothers, we would always talk about Saturday mornings. We never wanted to get out of bed because it was just my mom and dad fighting...it was horrible.

Similarly, Amber also described her family's stressful home environment, "There was lots of yelling...you could cut tension with a knife...our family just went from one crisis to another, to another, to another."

In sum, as this contextual framework exemplifies, the diversity of women's childhood experiences provide a rich backdrop on which their narratives about bulimia are more meaningful. While the African American women and Latinas spoke of varied contexts in which they developed, from countries of origin, to schools, to family environments, perhaps the most homogenous group in this study were the Caucasian women. This next section will expound upon the many emergent themes related to the women's understandings of their bulimia, and will continue to identify the diversity of experiences throughout the women's narratives.

### Experiences with Bulimia

This section explores the emergent themes related to how African American, Latina, and Caucasian women described their experiences with bulimia, specifically through the lenses of their racial/cultural and familial contexts. It is important to note that while the women often spoke in causal language, such that a particular factor or process *caused* the development of their eating disorder, the purpose of this section is to simply present the women's experiences as they understand them, and not necessarily to determine a causal relationship between specific experiences and the development of their eating disorders.

Emergent findings are organized into two categories. The first category, *common themes across all women*, includes issues about which women from all three racial groups spoke. While these themes were common to all groups, there were some differences in the frequency with which particular groups spoke of this phenomenon. It is important to acknowledge these racial/cultural differences in rates of occurrence, but due to the exploratory nature of this study I do not want to imply too much from these differences.

When differences exist, the frequencies for each racial group are noted; if no mention is made, then the frequencies are virtually the same. Furthermore, while there was no specific percentage that deemed a theme “salient,” all of the notable findings emerged from at least half of the narratives. The second category, *race-specific themes*, includes emergent themes about which only one or two of the racial groups consistently spoke.

### *Common Themes Across All Women*

This section explores emergent themes related to the women’s insight into their eating disorders that were salient in many of the narratives, regardless of race. These themes are organized into three categories: sociocultural processes, family processes, and individual psychological processes. The order of themes in each category was determined based on the total percentage of women who addressed the issue, such that the theme addressed by the largest number of women is explored first and the theme addressed by smallest number of women (but still considered salient) is discussed last.

#### *Sociocultural Processes*

Across all three racial groups, many of the women cited two sociocultural processes that influenced their experiences with bulimia, which included participating in sports and comparing their bodies to other females.

*Participation in image-conscious sports.* Nearly 80% of the women participated in sports at some point throughout their childhood years, the majority (81%) of which were image-conscious activities (meaning their body size and shape were important components of the sport). Participation in dance was the most popular sport, cited in 2/3 of these women’s narratives. The intense competitiveness and pressure to be smaller, especially in ballet, shaded these women’s memories of their days as dancers. Heather

(C) recalled how her early years in dance eventually became a significant component of her battle with bulimia:

I always had a body image thing and I don't know, I think a lot of that was from dancing ...there were times where we would have to get weighed every class...so I was always the biggest one and they would call out your weight and it was terrible. And girls were always running to the bathroom right before they got weighed.

Similarly, Sophia (L) shared how her participation in ballet influenced her body image:

Ballet gives you this image of what you're supposed to look like. When I moved here and I was taking ballet, the teacher told me to lose weight and I didn't think I weighed that much; she said, "Just cut down on the cheeseburgers"...if anything sent a big message, it was dance.

Other image-conscious sports cited in the women's stories included figure skating, swimming, cross-country/track and field, cheerleading, and gymnastics. Overall, regardless of the specific sport in which they participated, these women felt like the pressure to be slim enough, tall enough, and/or pretty enough was "hard" and "crazy," and later influenced their understanding of why they developed bulimia.

*Comparison to Other Women.* Another theme that universally emerged from half of the women's narratives with respect to sociocultural processes was their intense desire to look better than other women, while at the same time rarely speaking about a desire to seek the attention and approval of men. Unlike other studies on sociocultural comparison, in which most women compared their bodies with other women but did not necessarily feel negatively about their bodies (e.g., McCabe, Ricciardelli, & Ridge, 2006), the "girl competition" among the participants in the present seemed to generate a lot of anxiety, particularly when they felt like they were not as pretty or as thin as other women around them. For instance, Andrea (L) noted, "It was a competition. You want to be one of [the pretty girls], you want people to look at you like they look at them." Similarly, Jennifer



(L) also recalled the competitiveness she experienced, “The girls I hung out with...you had to look a certain way...everybody was thin.” Finally, Emma (C) recalled her obsession with not being “as thin as” her beautiful roommate, who she described as looking like Angelina Jolie; Emma’s bulimia later began while she was home alone and imagining her beautiful roommate enjoying a night out on the town with attractive girlfriends and handsome men.

### *Family Processes*

Family relationships, a primary focus of this study, emerged as a tremendously important component in how women described their eating disorders. The familial issues that emerged across all three racial groups include: ineffective family communication, strained parent-child relationships, focus on family’s social image, decision to tell family about bulimia, age-inappropriate role in family, sibling relationships, family focus on body image, and parents’ relationship conflict. As this section explores the relationship between the family context and the women’s experiences with bulimia, it is imperative to remind readers that speaking about the role of family in a person’s eating disorder is not the same as *blaming* a family for this illness. As the literature review for this study demonstrated, there are processes at multiple ecological levels that influence a woman’s experience with her eating disorder; family contexts are only one level and only account for a portion of this process.

*Ineffective family communication.* The family’s (in)abilities to communicate with each other emerged as a very salient theme throughout many of the women’s narratives. In fact, 82% of the women explicitly described unhealthy or ineffective forms of

communication, which centered around the families' evasion of deeper, more personal communication and families' avoidance of or engagement in conflict.

An overall lack of communication among all members was by far the most commonly cited issue in these families, described by 74% of the women. Most women noted that the family's communication was very "superficial," "basic," and "surface." Seemingly important issues, such as parents getting divorced, the death of a close family member, or somebody's physical or mental health, simply were not discussed in most families and instead were "swept under the rug," making it feel like there was always a "big elephant in the room." From a very early age, the women learned which topics were considered taboo in the family, and what things they were allowed to discuss. Sarah (C) recalled a time when it seemed only appropriate to talk as a family, but instead silence permeated the home, "My parents aren't really willing to deal with things...like they didn't deal with my grandmother's death, my mom's mom; she's from England. We went to England one day for the funeral and came back and never talked about it." She later spoke about how this lack of communication played "a part" in her understanding of why bulimia developed. Mariana (L) also recalled a pivotal moment when she learned that open communication was not acceptable in her family:

I'd remember my parents would punish me or they would put me in time out and I would always ask, "Why?" or sometimes at night I would write them a note and I'd slip it through their door and I would ask, "Why did you do that?" or "Why did you punish me?" or "Why did you hit me?" or "Why that?" And they would never answer. They would *never* answer but I would always voice what I was feeling, whether it was through a note or whether arguing, etcetera. But they would never really answer; they were just, "Oh, whatever, let it go"...but then as I got older I just never really said much to them anymore. I remember attempting to talk to them but they really, it wasn't easy talking to them so I just kind of stopped.

Additionally, Anne (C) is still bothered by the fact that her parents “never explained” the reasons for their divorce, “Neither my brother, my sister, or I could tell you why they split up.” Again, issues that were important to the women as children, even if not important to the parents or other family members, were not open for discussion. As Amber (C) summarizes, “It was just assumed that if you were sad, you would keep it to yourself; you wouldn’t talk about it.”

The attempt to avoid conflict and stress was a common reason cited for *why* these families refused to talk about anything beyond superficial issues. Heather (C) recalled a story about her dad’s health that illustrated the basic level of communication at which her family functioned and how everyone in the family, including her, worked hard to avoid conflict:

At one point my dad was going through a lot of tests for a blood condition and they won’t tell [me and my siblings] anything until it’s over...so after it was all over they tell us about it, but it was like, they’re very secretive...I ended up being secretive back then because I knew they wouldn’t put up with, if I thought that they wouldn’t approve a boy I was dating or something, they don’t know half the things that went on in my life because I just knew that, even now I hide stupid things from them just because I would rather not even discuss it because it’s too, it’ll be some stupid discussion of argument and it’s not worth it.

Sophia (L) recalled her family’s avoidance of conflict based on religious beliefs; even though she wanted to talk and learn about developmentally appropriate issues, she knew it would cause problems with her mom’s religious orientation, “Anything that went against the religion was not discussed, for example drugs, alcohol, sex, or anything that conflicted with her beliefs.” Finally, Lynn (A) talked about how her family’s desire to avoid conflict during her childhood persists today, “I still don’t feel like I can’t be on the same page and it’s okay. Whatever things that we don’t agree on we just don’t talk about it.”

Families who actually allowed conflict to escalate accounted for only 27% of the narratives. Words and phrases like “explode,” “blow up,” “screaming,” “confrontational,” “yelling,” and “in everybody’s face” were commonly used to describe the home environments for these women. When asked how families talked about issues of importance or disagreement, Jennifer (L) recounted the volatile relationship she had with her mom growing up, which eventually caused Jennifer to move out and live with her maternal grandmother right around the same time her bulimia developed:

I mean she would just go off and scream. Like, she would just get pissed off. I just remember her being pissed off all the time...she would yell a lot...it would just make me angry. She wouldn't want to talk; she'd never talk. All she did was yell...she was pissed off at other stuff and then I was making it worse and then she was even more pissed off.

Christine (C) also recalled a conflicted relationship with her dad, in which she was hurt by his comments and even more hurt by the fact that her mom did nothing to stop him:

She is very sensitive, doesn't show emotion very much, and my dad is pretty much exactly the opposite. He says whatever is on his mind, very hurtful things; he is the master of the guilt trip and very well can say some very hurtful things...he helped blow up everything into a bigger deal...my mom will just sit there and take it, even when he says things to me, which I'll get to [later] because that is a huge part of the development of [bulimia].

These tense relationships most often led to yelling matches between the daughter and her parent(s), which sometimes ended with slammed doors and orders to “Get out!”

*Strained parent-child relationships.* Eighty-two percent of the women in this sample reported having a strained relationship with their mom and/or dad. For the purposes of this study, “strained” relationships were characterized by the women’s perceptions of having little or no communication about personal issues, emotional distance, constant parental criticism and overprotection, poor/no parenting and lack of guidance, and parents’ overly high expectations.

A strained mother-daughter relationship was reported by 59% of the women. Two reasons for this disconnect commonly cited by the women include superficial communication and the moms trying too hard to be their daughters' friends rather than providing maternal guidance throughout life. Superficial communication, in which the women felt like they could not connect with or talk with their moms about personal and deep issues, emerged from many of the narratives. For example, Kayla (L) described what it was like growing up with her mom and what she wished it could have been like:

I never went to her to talk to her, to talk about deep subjects. I never involved her in my school life...if I could tell my mom everything and she would be supportive or really open-minded that would be great I think, because it's just one more friend. But, I couldn't tell my mom everything because I know how she is. She's too overprotective to be supportive at all or let me speak my mind without giving me some type of negative response.

Elizabeth (C) recounted a similar memory of her mom, "I never told my mom about my personal life. If I was having any sort of drama with friends, or if I sort of liked a boy or anything like that, never talked to her about it." When asked what the ideal relationship with their mothers would have looked like growing up, common responses included wishing for "a deeper connection," "to feel super comfortable," and simply "to be close." As these quotes demonstrate, the women craved a more cohesive and open relationship with their mothers.

It is important to note here that while many of these women with strained relationships felt like they couldn't open up to their moms, over one quarter of the participants did actually report feeling comfortable talking with her even though the relationship was not ideal. For example, Sophia (L) recalled *always* fighting with her mom during childhood, but in the same breath noted "there's times where I definitely open up to her and talk. She's really good to talk to and I confided in her. Our

personalities do clash; there's a lot of tension there." Similarly, Marissa (L) expounded upon her need to talk with mom when things got stressful in spite of their rocky relationship, "She's the last person I need but she's my mom so it feels only natural." While it can be tempting to focus on what is wrong in the family and dwell on what parents could or should be doing, this finding highlights the importance of illuminating what is going well in spite of other problems. For these women, their moms were successful in fostering a relationship that at times allowed for open and honest communication, even though other components of this relationship were not as strong or supportive.

The second reason why many of the women felt like the relationship with their mom was strained was the lack of maternal guidance. Many of them reported being treated more like their mothers' friends and confidants rather than their daughters. This dynamic was confusing and destructive for the women, particularly at developmental stages when a mother's direction was desperately needed. Some of the women felt like their moms were trying too hard to be their friends, like Marissa (L) whose mother was only 19 when Marissa was born. She recalled how frustrated and confused she felt with her mom's inability to parent:

Ever since I was in the teenage years, she kind of saw me more as a friend so we would like go out together. She's the worst person for me to be with if I'm trying to control being with guys because she's right along next to me, "Hey, hey." It's horrible... Oh my god I just wish that she had the opportunity to live her life so that she could have some point of reference to be able to raise me.

Other women felt like their moms relied on them for relationship advice, like Amber (C) who recounted the times when she felt constrained by her mom's desire to

inappropriately engage in friendly girl talk about her husband (Amber's dad), which she later spoke about in relation to her experiences with bulimia:

You have to keep it together for her. It'd be nice to let it go...It never was a mother-daughter relationship; it just was like you talk to your best girl friend. Like, "Oh I'm having trouble with my boyfriend." And then it was, "Oh, I'm having trouble with my husband." And I was like, "Please don't tell me these things,"... She's just kind of, it's always been, "Well, what do I do? What do I do? What do I do? What do I do?" And you get to a certain point where, "You know what? You got to figure this stuff out on your own at some point. Can you please, you have counselors, can you please ask them?"...at some point a girl just wants a mother...and I've never had that. After everything that's gone on, everything, I have yet to have that chance to really, truly, I think that's why I'm still not able to get over anything. I don't know, maybe one day.

Finally, Lynn (A), whose mom was in a very abusive marriage and tried to compensate for the stress her three children endured, noted how their early "best friend" relationship eventually turned destructive and unsupportive:

She tried to make things so much better just because she knew it was pretty bad...and then when she separated it was kind of like we still maintained this friend relationship, like you're going to let me do whatever until the point that it just spiraled out of control and I was out of control and I really didn't have respect for my mother as a parent because once she got separated and divorced she wasn't there a lot. She was out hanging out, going to clubs, just going to do her, have a free life, and so at that point I was kind of like doing whatever and then once she met my step-father and started dating him, she was home a little bit more so then she started wanting to be a parent again and at that time I was so out of control, I resented it and we butted heads all the way until I moved out.

As these quotes illustrate, many of the women felt as though they could not rely on their mothers for appropriate parental guidance, which eventually led to confusing and strained relationships throughout adolescence and into early adulthood.

Other reasons given for why the mother-daughter relationship was perceived by the women as strained included mothers disparaging the daughters' fathers after a divorce or separation, criticizing their daughters' weight and food intake, and pressuring their daughters to adopt or maintain a lifestyle more closely aligned with the family's racial

culture and less with the larger American culture in which they lived. These last two reasons were often discussed in tandem with other family members, and not just the mothers, and so they are explored in depth at a later point in this chapter.

While the majority of women reported having strained relationships with their mothers, there was a contrast by race in the frequencies of women who described overall healthy relationships – 57% were African American, 29% were Latina, and only 14% were Caucasian. For example, Samantha (A) described her single-mom, with whom she had a very close relationship, “She made time for us. If no one else was there, she was there, she was always there...and I think definitely with the love and support of my mother, I was able to defeat my problem.” Similarly, Andrea (L) spoke very highly of her mother, “She was always there for everything...probably the most important person in my life is my mom.” While 86% of these positive reports were given by minority women, it is most interesting to note that the African American women were three times more likely to describe the relationships with their mothers as healthy and positive than as strained; this is in contrast to the Latinas and Caucasian women who were at least twice as likely to report more strained relationships with their mothers than healthy and positive ones.

Similar to the important role of mothers, the women’s relationships with their fathers were also significant components of their narratives. Using the same concept of “strained” relationships as was used with the mothers, 58% of the women reported having an unhealthy relationship with their fathers, which is virtually equal to the number of strained mother-daughter relationships. The reasons for why these relationships were considered strained include fathers’ emotional distance, physical absence, and abuse.



Emotional distance, in which the father was physically present but emotionally unavailable, was discussed in 47% of the women's stories, making it the most common reason cited for why they felt like the relationships with their fathers were strained. This distance was characterized by dads being "removed," "anxious," "uninvolved," and "busy." Additionally, Lauren (A) highlighted her dad's inability to express positive emotions and affection, "For a long time, my father did not say that he loved me, he did not give me hugs, he didn't know. He didn't raise us." These women simply yearned for the affection and engagement of their fathers. With respect to race/culture, Latino fathers were the least likely to be emotionally distant from their daughters, accounting for only 11% of the disengaged dads; African American and Caucasian dads were equally likely to be distant, accounting for the remaining 89%.

Absent fathers, in which they were not living with their daughter and made little or no attempt to be a part of her life, accounted for 37% of the strained father-daughter relationships. Samantha (A) spoke at length about the pivotal role her absent father played in her life:

I was eleven years old and it was almost Christmas and he told me and my sister that he had a present for us and so when Christmas came we found out that he had left for North Carolina, and I couldn't understand that. I couldn't understand how that would be something to make me happy. I couldn't understand how that's a gift, to leave...I think that when he left there was a point of depression, when I started eating a lot more, and then there was the problem...I felt like my father didn't love me and so that made me feel bad about myself, make me think that I must be a bad daughter or that I must not be wanted.

Additionally, Celestine (L), who moved to the U.S. with her mom at age 6 thinking that it was a temporary visit and that she would soon be returning home to live with her dad again, spoke to how her distressing feelings were inextricably linked to the absence of her father, "I always felt very alone and very hurt because I didn't have my father."

Furthermore, Wanda (A), who was adopted at birth and rarely saw or heard from her adopted father after age 3, summarized her pain related to his absence, “I wished that I had a dad...I think I’ve always had, felt like I had some sort of a hole to fill in me, so it was something, it was the fact that my dad wasn’t around.” An analysis by race revealed that of all the physically absent dads, only 14% of them were Caucasian, and the remaining 86% were evenly represented by African American and Latino fathers.

Emotional, physical, and/or sexual abuse between fathers and daughters accounted for only 16% of the relationships. These dads were described as “mean and hurtful,” “authoritarian,” “angry,” “critical,” and “harsh.” The effects of this abuse are discussed in more detail later in this chapter in tandem with the women’s feelings of being “out of control.” Unlike the emotional and physical distance between fathers and their daughters, there were no differences by race in fathers’ tendencies to abuse their daughters.

In sum, differences by race in the father-daughter relationships revealed that African American and Caucasian dads were more likely than Latino fathers to be emotionally distant, whereas African American and Latino fathers were more likely than Caucasian dads to be physically absent from their daughters’ lives. While the Latino and Caucasian fathers were more likely to be described by their daughters as emotionally *or* physically distant, the African American fathers were more likely to be described as both emotionally *and* physically distant. As a result, of all the strained father-daughter relationships reported, nearly half of them were between African American fathers and daughters. Furthermore, of all the African American father-daughter relationships, 73%

of the women spoke of a strained relationship with their fathers, in contrast to only 45% and 54% of the Latina and Caucasian father-daughter relationships, respectively.

Similar to the mother-daughter relationships, there were also positive accounts of the father-daughter relationship in 42% of the narratives. For example, Debra (A), who grew up living with both parents and three siblings, described her relationship with her dad as being very healthy and supportive, “I think we have an understanding...he understands me more than anybody else in the family.” Cara (C), who also grew up with both parents and three siblings, similarly highlighted the unique bond with her dad:

When I was really little I was actually closer with my dad. He was kind of like the good guy and my mom was the bad guy, I guess...he was just, never got mad at me and yelled at me as much as my mom did, so I guess I just felt safer with him.

Recalling the days when they were “daddy’s little girl” served as a very positive and warm memory for these women.

In addition to specific qualities of the relationships with each parent, the theme of parents’ excessive work hours also emerged as a common reason for why the women felt they had strained relationships with their parents. Nearly half of the women reported having at least one parent who spent a significant amount of time working away from the family. It was not always indicated why the parent worked long hours, however some women did note that their parent had to work two jobs out of financial necessity (often a single-parent); other parents really enjoyed their jobs and wanted to work; and still other parents simply used work to escape the stress of home, particularly on the weekends. While there were no differences in which parent was working (38% were dads, 38% were moms, 25% were both parents), there were differences by race. Nearly half of these

working parents were African American, and the remaining half were evenly split by Latino and Caucasian parents.

At this point in the chapter it is important to note an interesting finding that emerged from the women's narratives about their families because it speaks to the caution with which this theme of strained parent-child relationships must be interpreted. When specifically asked, "How do you make sense of why your eating disorder developed?", only 42% of all the women specifically noted the relationship with their mom and/or dad (with no notable differences by race); this is in sharp contrast to the 82% of women who simply identified a strained relationship. Thus, only about half of the women who struggled with the relationship with their parents actually considered this to be an important component in their understanding of bulimia. Furthermore, of these women who cited this strained relationship as significant, 14% *only* cited parent-related issues when trying to describe their illnesses; the remaining 86% of the women also cited issues outside of the family, such as intimate relationships and teasing at school, as being important issues to consider when trying to understand their illnesses. Thus, when considering the entire sample of this study (and not just the women who spoke of strained parent-child relationships), only 6% of the women truly identified their parents as the sole issue in understanding their eating disorders. This emergent finding is critical in dispelling the persistent myth that parents are to blame for their children's eating disorders. In fact, one of these two women, Anne (C), even spoke to the issue of blame after identifying her parents as the "reason" for her illness:

I think at first I thought it had nothing to do with my family. I really remember the first time I went to treatment I didn't want [my parents] involved, not because I hated them, I just didn't think they had anything to do with it. I think now they had *everything* to do with it, not to place blame on anybody or to say it was their

fault. I just see how I looked at things in our family and how I took that upon myself and turned it all inward to where I had like my family in me all the time.

So, as these findings suggest, parents may or may not be a piece in solving the eating disorder puzzle; and if they are considered a piece of the puzzle in the eyes of their daughter, then it is very likely that they are not *the* piece, but simply *one* piece.

*Focus on family's social image.* Another salient theme that emerged from the women's descriptions of their families is the overwhelming amount of attention given to the family's outward appearance to neighbors and other community members. When asked, "How would the neighbors have described your family back then?", 82% of the women predicted very positive perceptions that the neighbors were likely to have of their families. They used words like "normal," "happy," "perfect," "all-American," "successful," "loving," "fun," and "friendly" to describe what others may have seen, which would have been gathered by witnessing the families going to church together, celebrating holidays together, gardening in the yard, attending community events together, and opening their house to the neighborhood kids, among other things. Yet in spite of these seemingly positive family environments, 90% of the women then went on to describe stark differences in what family life was actually like "behind closed doors." Parents' abuse of alcohol and drugs, ongoing arguments and conflict, quiet tension, financial difficulties, and lack of affection were cited as common truths about their families that often went unseen by the neighbors. For example, Michelle (A), whose family was known by the neighbors as The Huxtables, recalled the truth behind closed doors, in which she never doubted her parents' love for her, but yearned for them to express this love:

It's like nurturing but not affectionate at all, no affection... I wanted it to be different. I wanted to just hear I love you, I'm proud, or like I used to, my father when he used to go to work, he's a police officer. Well, whenever he went to work, whenever he left the house, he would give my mother a peck and I remember some years I would wait for him because it was like a routine. He would get dressed, come downstairs, my mother made his lunch, and he would give her a kiss. And I used to wait for that because it was the only type of affection I saw.

The women also described ways in which their parents tried to compensate for this dissonance in what the neighbors perceived versus what actually happened. For example, Emma (C) described her mom's efforts to preserve whatever positive image the neighbors may have had, in spite of their "broken," fatherless home:

They wouldn't have seen the arguments, even like my mom, she'd be like if I was yelling at the top of my lungs and upset at her, she'd be like, "Shut the windows" kind of thing... "don't yell at me from outside."

Amber (C), who noted a lot of turmoil, yelling, and abuse in her family, sarcastically shared how her parents tried to dispel any skepticism about their family's possible negative image among the neighbors:

Any of the times that the police showed up, it was all written off as, "Oh it was a mistake"...so [my dad] would tell the neighbors that they were friends and they'd show up with their lights on as a joke or something and just wanted to distract the neighborhood. We have a bird and we have a macaw, who's really noisy and so that was also our cover. And now I know why we have a bird that is really, really noisy. That's why the police would show up; it was the bird and somebody reported the bird. It was the bird yelling and not us yelling.

As these narratives indicate, nearly all of the women grew up in family environments that very much valued what others thought of them, but did not always present a truthful picture of their lives behind closed doors. Consequently, women felt as though they were not allowed to disclose the truth about their home life, which further exacerbated the cycle of unhealthy and destructive communication patterns present in most of these families.

*Decision to tell family about bulimia.* Seventy percent of the women opted to disclose their secret to at least one family member, however this decision to tell was often an internal process riddled with pain and uncertainty. Prior to telling, many of the women “dropped hints” about their eating disorders in the hopes that somebody would reach out to help them; however, when confronted about their illness they often denied any problems and refused offers for treatment. Jessica (C) described this confusing and contradictory process when she recounted the days spent in her guidance counselor’s office talking about her symptoms. Internally, she wanted her counselor to call her parents and tell them what was happening, but what she outwardly communicated time and time again was, “Don’t tell my parents, don’t tell my parents.” Elizabeth (C) also articulated this dissonant process during her battle with bulimia:

I guess there was kind of a dual thing going on, because at the same time like I wanted them to know what I was going through, because I wanted to have these close friends that understood me, but at the same time it was like, “I cannot tell them how crazy I really am.”

Additionally, many of the women became “a little bit more careless” with their symptom use in an effort to subtly reveal the disorder to their family, however most family members “never got it.” Whether people just did not identify the constellation of symptoms as an actual eating disorder or were simply in denial that a problem existed, the women reported feeling surprised at the lack of responses. For example, both Kayla’s (L) and Madison’s (L) moms attributed their lack of eating to the “pressure” of balancing high demands at work and school; Lisa’s (A) mom thought her daughter’s sudden weight loss was due to puberty and not hours in the gym everyday; and Margie’s (L) mom thought her daughter’s eyes were red and watery because she had just washed her face, and not because she had been vomiting.

Eventually, 70% of the women told at least one person in their family, often their mom and/or dad. For the women who opted to not tell their families, a host of anxiety-provoking thoughts and feelings contributed to this decision. Of the women who did tell, some found their family's reaction to be helpful in facilitating recovery; while others felt unsupported. Motivating reasons for the women's choices to tell or not tell are discussed.

For the one-third of women who had yet to tell their families about bulimia, they feared being judged and criticized, and they also feared being a burden. Fear of judgment and rejection was defined by the women as people thinking "badly" of them or considering them "strange" because they have an eating disorder. Heather (C) recalled how much she wanted to share her secret with her older sister, but shied away from the opportunity out of fear that she would be cast in a negative light. Similarly, Wanda (A) described why she had yet to be honest with her mom about bulimia:

I want to tell her but I don't know what would happen and there's a worst case scenario and a best case scenario with lots of stuff in the middle and I just don't want to deal with any of it. It's very risky.

This risk of emotional and psychological vulnerability became too much for some women and prevented them from opening up and sharing their story with loved ones.

Additionally, some women feared that this news would unnecessarily "burden" their parents who already "had a lot on their plate" with tending to the demands of day-to-day life; exposing this secret would simply "add to it" and not be helpful for anyone. Cara (C), who acted as a second mother to her two younger sisters and consoled her mother during bouts of depression, expressed feelings about not wanting to overwhelm her parents with her troubles, as they were preoccupied with their own marital discord



and mental health issues, “I never really felt like there was room for me to have this problem. I always felt like there were too many problems going on.”

Among the three quarters of participants who opted to tell their families about bulimia, 70% of them did not feel supported by one or more family members. Phrases like “we didn’t talk about it,” “never really bring it up,” “left it alone,” and “never checked in to see” were common descriptions of family members’ non-supportive reactions. This attempt to maintain homeostasis by not confronting the illness created a palpably anxious environment for the women. Noel (C) recalled how her mom was “walking on egg shells” after she learned of her daughter’s bulimia, “She didn’t want to set me off...just like leaving me to my own devices, not wanting to say the wrong thing so not saying anything.” When later asked if it would have been helpful for her to have the family talk about these “bad things,” she replied, “Yeah, probably, but that’s just not how my family is. They don’t talk about anything.” Jessica (C) also recalled tense moments with her parents after being discharged from the emergency room for complications brought on by her eating disorder, “I remember that night coming home and my dad had dinner ready. It was just so weird. We didn’t talk about [bulimia], and so I just continued to hide it.” Like Noel, Jessica also wished she could have talked openly with her mom about bulimia.

Two reasons cited for why the women believed their families were not able to talk about bulimia included parents’ unresolved trauma from their childhoods, and their lack of knowledge about eating disorders. Several women noted their parents’ own unresolved trauma as important in understanding why their families never directly addressed the eating disorder. For example, in talking about why their parents were not as helpful as the

women would have liked, Lynn (A) hypothesized about her single-mom's inability to show empathy for her daughter's emotional struggles:

My mom has lots of issues she's never ever addressed. She was sexually abused by her brother...I think that a lot of the issues that I've gone through are a mirror image of my mom...I think that's why she's so hard on me about it, because my mama's the kind who just picks up and moves on and she feels like I should be able to do the same.

The women's appreciation of their parents' "transference of their own insecurities" provides a compassionate perspective as to why communication was so stifled in these families – it's not necessarily that the parents did not *want* to talk about the illness, but perhaps they simply did not know *how* to address such a complex and frightening issue.

Second, women also spoke to their parents' lack of specific knowledge about eating disorders that hindered their abilities to talk about the issue. Many of the women felt like their parents were so focused on the food aspects of the disorder that they were unable to see the more intricate dynamics of this disease. For example, Sophia (L) recalled a very hurtful comment from her mom, which indicated her mother's lack of knowledge about the true nature of bulimia:

My mom does not understand eating disorders. One time she told me I was wasting food. She said, "You're wasting our food," and, that was upsetting. I still remember that. That was one of like the worst things she ever said. She does not understand it at all.

This lack of understanding about eating disorders was often paired with parents being overly calm about the situation. Their beliefs that bulimia was "just a phase" or "not a big deal" further contributed to the women feeling worthless, unimportant, and dejected. When Madison (L) finally opened up to her mom about her struggles with "eating too much" and "feeling guilty," her mom replied, "No way, you're fine. Just do a lot of exercise if you start feeling like that."

Finally, of the women who told their families about bulimia, some of them found their parents' "hovering" to be a non-supportive reaction that certainly did not aid in the recovery process. These behaviors often included intently watching their daughter eat every meal, following her to the bathroom, and then asking her, "Did you throw up your food?" once she returned from the bathroom.

In addition to the 70% of women who felt unsupported by certain family members after telling them about bulimia, about 2/3 also received positive replies from at least one family member. Supportive responses were defined by the women as "accepting," "loving," "understanding," "concerned," "encouraging," and "non-judgmental." For example, Andrea (L) was lovingly confronted by her mom and sister after being caught purging, and she recalled their very empathic response:

It was difficult but [my mom] knew that I was going to be able to get over this, I'd be okay. And the same as my sister; my sister was like, 'You know what? You're going to be fine. We're going to help you; we're going to go through this with you. You don't have to worry, whatever you need.'

Eventually, with her mother's unwavering support and encouragement, Andrea was able to give up her eating disorder and "definitely" considered herself recovered at the time of the interview. Samantha (A) recalled a similarly gentle response from her mother after confessing to having bulimia while they watched a news story together about a young woman with an eating disorder, "When she found out, she didn't judge me, she didn't yell at me; she cried...she helped me."

Most interestingly, there were cultural differences in how families were perceived as supportive. Of the African American women who told their families, 67% of them felt supported, and of the Latinas who shared their secret with family, 75% felt supported. These numbers are in contrast to only 44% of the Caucasian women who told their

families and then felt supported by their responses. Additionally, of the families who were perceived as supportive, half of the Caucasian and Latino families assisted their daughters in seeking professional treatment (e.g., hospitalization, individual therapy), whereas only 1/3 of the African American families sought professional help. Cultural reasons for this discrepancy in seeking treatment, as identified by the women, are discussed in the second section of this chapter in tandem with other sociocultural processes.

*Age-inappropriate role in family.* The women's roles in their families, particularly during the adolescent years, led many of them to feel burdened by the expectation to be inordinately adult-like and responsible. Nearly two-thirds of the women talked about the expectation in the family to be "mature," "perfect," "self-sufficient," "responsible," "reliable," "strong," and "stable." For some of these women, this premature responsibility manifested through having to emotionally support a parent during a difficult transition or serve as a second mother to a younger sibling. For example, Lynn (A), the oldest sibling with three younger brothers, recalled how she was encouraged by her mother to be the responsible parent and look out for the well-being of the boys:

If they would ask if they could go to a party, she would be like "Don't ask me, ask your mother," because I'd be like, "What? I can not believe you let him go there. It was so late, where is he?"

However, other women recalled having to be home alone or earn a job at a very young age, simply because of the family situation at the time. For example, Samantha (A) remembered being the youngest child but always feeling like she had more responsibility than her older siblings:

I just grew up faster than everyone else...I started going to school by myself earlier because I was last in school...I started crossing the street by myself earlier. I had to grow up earlier. When everyone else, like my aunt and my brother like 17 still trick-or-treating, I had to stop like age 10...I started working at age 11...I would go places by myself. I've always been a loner.

Still other women just sensed an unspoken expectation to be the “good child.” Whether they acquired this through earning high grades in school or simply not being “bad,” these women worked hard to make their parents “proud” and make things at home “easier.”

*Sibling relationships.* The participants’ relationships with their siblings unexpectedly emerged as a salient component of their experiences with their families for about two-thirds of the women. All of the women grew up with at least one sibling; the average number of siblings was 2.2, and ranged from one to five brothers and sisters. The number of siblings in the present study is very similar to the average number of siblings in U.S. families, which is 1.86 (U.S. Census Bureau, 2004). With respect to siblings’ genders, 39% of the women had all sisters, 24% had all brothers, and 36% had a combination of brothers and sisters. Interestingly, 52% of the women were youngest siblings, 30% were oldest siblings, and 18% were middle sisters. Statistically, it seems plausible that there should have been a fairly even split among the three groups of birth order (oldest, middle, youngest), however this sample overrepresented youngest daughters.

Of similar interest, about one-third of the women had a next older or next younger sibling who was at least seven years apart in age, and the African American and Latina women represented 83% of these sibling relationships. Three quarters of the women with siblings significantly distant in age were the youngest sister with a next older sibling who was 9 years older.

The degree to which the women felt like they had emotionally “close” or “distant” relationships with their siblings was somewhat similar, with 55% reporting having a distant relationship and 73% having close relationships. The total of these percentages exceeds 100% because some of the women described having a distant relationship with one sibling, and a close relationship with another sibling, thus creating an overlap in the types of relationships reported.

Emotionally distant relationships were characterized by a variety of processes, including typical sibling rivalry, disparate personalities, significant differences in age, and inappropriate parent-child interactions. The significant difference in age for over one-third of the participants emerged as an important issue in their feelings of loneliness and isolation, which influenced their understanding of why bulimia developed. For example, Jessica (C) grew up with two older brothers who were 10 and 12 years apart in age from her, and she recalled many times when she was left out of their lives, “I wanted to be included in what they did but that was unrealistic because their lives were so much different.” After her brothers moved out of the house, Jessica noted feeling very “alone” and having to spend long days in before- and after-school care since nobody else was around to care for her while her parents worked. Michelle (A) also recalled a similar desire to be more included among her four siblings who were between 13 and 17 years older than her, “They were just so far along in age that I was still just like the baby. So, it wasn’t like ‘Come with me, let’s go hang out’ type of thing; they were all hanging out with each other.” She went on to talk about how when they did spend time together, her siblings considered it “baby-sitting” rather than just “spending time with me.”

Additionally, Celestine (L) always felt “in the way” and “like a little bug or fly in her way” while growing up with her half-sister who was eight years her elder.

Some women also reported a distant sibling relationship because they were either parenting one of their younger siblings (18%) or being parented by one of their older siblings (12%), which ultimately hindered their abilities to relate as siblings. Page (C) recalled having to be a second mother to her two sisters who were 6 and 12 years younger, while their parents developed a tumultuous relationship and turned to drugs to escape the pressure of life, “There was no structure, I did homework with my sisters and I cooked for my sisters...we didn’t get along and we fought and there was no room for appropriate sibling behavior.” Similarly, Mya (L) grew up with a distant older sister of 11 years who often took care of her as a child, and who continues to mother Mya in an inappropriate and irritating way:

My sister, it’s sort of like she had to take care of me because she was so much older than me, so often times she would take care of me as opposed to my mom...we’re still struggling with that a little bit...sometimes I would tell her that I’d be going on a date and she’d be like, “Oh, with who?” instead of saying, “Oh,” doing the sister thing, “What are you going to wear? Are you excited?”

As these quotes demonstrate, the inability for siblings to relate as equal children in the family and to appropriately support each other through important developmental transitions often led to feelings of loneliness and isolation.

In light of the fact that over half of the women felt like they had a distant relationship with at least one of their siblings, it is important to recognize that nearly 75% of the women also reported having a close relationship with at least one brother or sister, the majority of whom were African American. Some of the women recalled having “protective” older brothers and “caring” older sisters, while others enjoyed having a

friend with whom they could share personal things. In fact, two of the women even spoke to how they believed that this close relationship significantly influenced the course of their illness. Sarah (C) reported having a close and caring relationship with her older brother of two years within the context of a very emotionally distant relationship with their parents, and when asked how she understood why her bulimia developed, she recalled the trauma she experienced when he moved out of the house:

One of the things I think was that my brother was leaving for college and I was stressed about that, about being an only child...my dad worked part-time but my mom retired at that time and my brother was gone, so it was like "Oh my god," all the attention.

Heather (C) also recalled how the "very close" relationship with her older sister, in which she strived to be like her sister, contributed to her understanding of why bulimia developed:

My sister had always been bigger than me, much bigger than me, and she was a senior and I was a freshman. I remember I got to school freshman year and I thought, "Oh, my sister's lost weight"...it got to the point where she was just tiny and I would see her and if she's, I would feel terrible about myself. I've always compared myself to her...if I was around my sister, [bulimia] would get worse.

Interestingly, while both the Latinas and Caucasian women reported fairly equal numbers of distant and close sibling relationships, the African American women reported twice as many close, positive relationships (67%) with their siblings as they did distant (33%) ones. Half of these close relationships were situated in the context of one sibling caring for another in a parental role, such that an inherent level of respect for this hierarchy was built into the relationship.

*Family focus on body image.* In addition to the families' efforts to preserve a positive image to the outside world, many of the women also talked about their family's outspoken desire for all members to maintain a positive physical appearance. Nearly 60%



of the women identified family members' critical comments about their weight as important components in their understanding of bulimia. Respondents were three times more likely to report that their mothers criticized their weight and appearances than their dads. The message to lose weight and maintain a smaller figure was the epitome of these criticisms. Christine (C) recalled two moments during college when her parents made it very clear that weight gain was unacceptable. The first incident occurred when her mom came to visit her on campus, "So I remember [my mom] saying to me, 'Oh, I just wanted to let you know in case other people say something to you that you have gained weight,' and so I was extremely upset." She then went on to describe the conversation with her parents when she informed them that she wanted to transfer to a different university after not being accepted into her chosen sorority and then experiencing depression:

So [my dad] was trying to talk me out of it and saying just that what I need to do is join more clubs and then he came up with what I call the contract, which was three different things that he wanted me to do [before transferring]...he was like, "Why do you want to transfer?" and I remember him saying to me that, "Well, you know at Northwestern, that's a more image-conscious school and if you really want to make friends you should probably lose some weight"...so they added onto the contract to lose 15 pounds, so I was really angry about that.

Christine did actually end up losing a little bit of weight, earning praise from her father, who commented, "Now you look good." She never did transfer schools.

Other women also recalled times when their parents made it crystal clear that losing weight and/or keeping a trim figure were very important. Lisa (A), who later used excessive exercise to purge, recalled her dad's concern about the "weight thing" because of her mother's family history with being overweight, "I wouldn't say I was big, but he would have me riding bicycles." Margie (L) also recalled her mom's constant reminders to "don't eat, don't eat" and avoid second helpings:

She made me feel bad for eating, for wanting to eat more, and I was like, “Okay, no more.” So it made me feel like I was fat, and I was 10 years old. So, she’s like, “No, don’t eat that because it’s going to make you fat and you don’t want to be like that,” and so I was like, “Whoa, okay I’m not going to eat.”

For some of the women, these comments played an important role in their abilities to understand why they believed their eating disorders developed. For example, Bianca (A) shared:

[My mom] made back-handed comments. One time we went to Burger King and I was eating a whopper or something and she was like, “Make sure whatever you put in your stomach stays in your stomach.” I remember being really angry and I went and I [vomited]...she always had issues with making comments about my weight or whatever, so that was what had triggered it.

Ifeoma (A) also recalled feeling “bad” and like she was “disappointing people” after her mother commented, “What happened? You were really slimming down and you were looking so nice. What’s going on? Why are you gaining weight? You have to lose that.”

Similarly, Wanda (A) remembered the harsh response from her mom after she opened up about the increasingly distant relationship with her boyfriend and how sad she felt, “She’s like, ‘Well, maybe you’re not close to him anymore because you’ve gained all this weight’...then it was like, ‘Maybe my mom is right.’” As these women demonstrate, the constant reminders to lose weight, eat well, and exercise became their barometers for self-worth, at least within their families. Eventually, they were convinced that they were indeed too fat and unattractive.

In addition to their parents’ disparaging remarks about weight, many of the women also discussed unhealthy ways in which their parents enabled and facilitated disordered eating and dieting. For example, Jennifer (L) was only allowed to eat “all healthy food” and drink seltzer water, while Wanda’s (A) mom signed her up for Weight Watchers, NutriSystem, and OptiFast diet programs during middle school. Mariana’s (L)

mom made all of her children drink carrot shakes and eat salads on the weekends when they were not in school. Additionally, Margie's (L) mom bought her diet pills when she turned 18, and encouraged her to skip breakfast and lunch and just drink water all day if she started to feel hungry before dinner.

Related to the families' intense focus on their daughters' weight and appearances is the degree to which other family members were also affected by disordered thoughts and behaviors related to eating and dieting. This information is important in providing a contextual understanding of the intergenerational dynamics and genetic influences that seem to be passed from parent to child. Over half of the women described at least one close relative (mom, dad, sibling, aunt) as having an unhealthy relationship with food; almost all of these people were the women's mothers. While some of the women were unsure as to whether or not this person had a true diagnosable eating disorder, they were certain that destructive methods of weight loss were being employed. They recalled memories of watching their moms consume diet foods, losing large amounts of weight in a short amount of time, asking for purging "advice" from their daughters, spending hours working out, and weighing themselves at least once a day. Thus, many of the participants may have learned their destructive behaviors from their own family members, who in turn probably learned *their* unhealthy behaviors from previous generations, as well. The cycle in which these families seem to be stuck lends more evidence to the notion that families, particularly parents, do share some responsibility in creating a toxic environment for their daughter, but they are not to *blame* for their child's eating disorder.

*Parents' relationship conflict.* Discord between parents has often been found to be present in families affected by an eating disorder, and these women further supported

this finding. Over half of the women described their parents' relationships as "rocky," "abusive," "hateful," "destructive," and "problematic," and often cited "yelling," "fighting," and "screaming" as common occurrences at home. In contrast, only 29% of the women characterized their parents' relationship as "positive," "loving," and "friendly." The remaining 13% of women described their parents' relationship in neutral terms (e.g., length of marriage, occupations) and did not indicate how their parents related to each other.

Interesting and unexpected differences emerged with respect to how the African American, Latina, and Caucasian women described their parents' relationships. Both the African American and Caucasian women described the exact same number of negative, positive, and neutral relationships with their parents, in which 64% of these descriptions were not favorable. In contrast, about half of the Latinas provided positive descriptions of their parents' relationships, outnumbering the reports of negative (36%) and neutral (9%) relationships. Thus, while it seems as though the families represented in this study were afflicted by destructive partnerships, which would mirror previous research findings, it is more appropriate to report that discordant relationships between the women's parents were more prevalent in Caucasian and African American families than in Latina families.

### *Individual Psychological Processes*

While this study set out to primarily investigate racial/cultural and familial issues with respect to women's experiences of bulimia, some individual psychological processes emerged from many of the narratives that are important in understanding these women's experiences. These psychological processes included comorbid disorders, managing powerful emotions, and feeling out of control.

*Comorbid psychological disorders.* According to a mental health report of the U.S. Surgeon General (n.d.), anxiety and depression are among the most common mental illnesses experienced by U.S. adults; these disorders were also cited by 79% of the sample. Depression was most likely to develop during early to middle adolescence, right when the women were beginning middle and high school. Twelve percent of the women reported feeling suicidal at times in the past, but no longer felt this way at the time of the interview. The women provided little insight as to why they believed the depression developed, but did recognize that they were having a “really, really hard time” and feeling very “unhappy.”

In addition to feeling depressed, many of the women also developed intense anxiety and fear related to a variety of issues, including their appearances and making decisions about their future. The stress of possibly gaining weight and being fat was very overwhelming for some women, like Madison (L) who recalled the intense fear of gaining weight and then not being able to lose it, similar to what happened to her mother:

My mom, when she was my age she was so pretty, I mean the perfect body, the *perfect* body. I have pictures and those little things that you project and she was so pretty and then she got married and she started you know my dad she would make dinners and lunch outside and then she got pregnant...now my mom can't lose weight anymore. Even if she tries it's really hard...and I don't know if I'm going to be skinny like my tomboy sister or if I'm going to, so it was like no way.

Madison's worry, along with Debra's (A) and Sarah's (C) concerns about gaining weight and being stuck in a fat body, contributed to their understanding why they felt compelled to purge after meals, in the hopes that their bodies would stay slim.

In addition to feeling anxious about their weight, many women also reported feeling very restless about their futures. Often triggered by graduation from high school or college, not knowing which path to choose and which decisions to make seemed to be

the most common anxiety felt by these women. For example, Wanda (A), who earned a graduate degree in the arts but was seeking a different career path, recalled the times when she would binge and purge during her early adulthood years, “I graduate from school, I don’t know what I want to do. I don’t really want to do this singing because apparently I’m not good at it.” Similarly, Elizabeth (C), who was heavily contemplating her post-baccalaureate options at the time of the interview, tearfully explained how the daunting task of carving out a future stirred up intense feelings of anxiety for her:

Suddenly I had to start making bigger, more important decisions about my future. I had to choose a major, and that was *huge*. I’ve always been incredibly indecisive, any decision. I mean, I can spend ten minutes at the grocery store deciding what shampoo to get, and that’s ridiculous.

Additionally, Christine (C), who recently graduated from high school and moved out of her parents’ house, feared her ability to successfully navigate the future on her own:

My mom has always babied me a lot, that’s one thing that’s actually kind of scaring me now because I’m living on my own, I’m out of the dorm. I’m living in an apartment next year and I don’t know how to pay bills, I don’t know how to do anything because my mom, my entire life, has always taken, done it all for me.

As these women noted, their intense fear of the future created an atmosphere of anxiety and tension that shaded their experiences of bulimia.

An important subcomponent of the women’s anxiety that emerged from several of their narratives was obsessive-compulsive disorder (OCD), which has been shown to be a common trait among people with eating disorders. Rigid, distressing thoughts and related rituals are key symptoms of OCD, and often exacerbate the inflexible nature of an eating disorder. Emma (C), who grew up in an extremely rigid environment ruled by the conservative doctrine of her family’s religion, recalled how her OCD tendencies interfered with her daily religious observances:

I had gotten very OCD about certain prayers. If I was saying it and if it wasn't with enough fervor then I'd have to repeat words...part of the original reason why I did shed all of my observance in my early twenties, like around the time bulimia started, was because it was getting so difficult to do any practicing of it...it was very tough and I remember I'd have to touch certain body parts also at certain points throughout the prayers.

Marissa (L) also recalled her ritualistic tendencies, in which before she went to bed she would make her mom check all of the doors and the windows around the house, which provided a sense of safety in her mind. Finally, Lauren's (A) recount of her rigid lifestyle helps to explain how eating disorders are easily intensified by this inflexible way of thinking and behaving:

It wasn't just eating. It was, I had to have a certain number of hours working out every day. I had to do a certain number of...it was like this regiment. Okay, I'm only going to eat such and such and I'm only going to expel such and such, and I'm going to do this today...if I didn't follow that plan then I was a wreck.

*Management of emotions.* A second individual process that emerged from the women's narratives with respect to how they described their eating disorders was the management of overwhelming emotions through the physical acts of bingeing and purging. The cyclical nature of bulimia often mirrors the emotional roller coaster of loneliness, guilt, and anger, of which 58% of the participants spoke. Mya (L) summarized this cycle well when she recalled moving to a new state and feeling overwhelmed by her loneliness, which she believed was the start to her eating disorder, "I felt so lonely so then I would soothe myself with food and then I would feel guilty and it started all over again for a little bit."

According to these women, their binge eating was often triggered by powerful feelings of loneliness and sadness, in which they turned to food for comfort and companionship. Women were feeling lonely for various reasons, including a death in the

family, a strained friendship, a desire for romantic affection, and/or an emotional distance within their families. Samantha (A) expounded upon her loneliness, in which she felt abandoned by her absent father and distant from her mother who worked multiple jobs just to pay the bills, “We all had different ways of seeking that missing emotion, that missing satisfaction...I mean I used to cry and cry and then finally I thought that I had a solution.” For Samantha, her eating disorder provided a way to feel comforted when people in her life were not able to fulfill that basic need. Additionally, Wanda (A) turned to food because it was predictable, reliable, and “always there to comfort you.”

The next piece of the emotional eating disorder cycle is the guilt that develops after intense overeating, which then inflames existing feelings of anger and pain, and then ultimately leads to unhealthy compensatory behaviors. While the majority of women in this study utilized a variety of compensatory methods (e.g., diet pills, excessive exercise), self-induced vomiting was the most commonly cited method related to the management of these strong emotions. Unlike more passive approaches of ingesting pills or working out for several hours, vomiting provided an unrivaled, albeit brief, catharsis. Anne (C) recalled the overwhelming emotions she experienced the night that her dad realized she had been throwing up after meals, “I felt so open and so violated and so embarrassed and angry. If there was ever a reason to want to throw up, that was it. I just felt terrible.” At this point, Anne’s eating disorder had become a regular coping strategy for stabilizing her strong emotions, even when those emotions were directly related to the eating disorder. Eventually, though, this stability is lost and bulimia’s “fix” is needed again to reinstate those feelings of comfort and relief.



It is interesting to note, however, that the frequencies of this theme were somewhat different across the three racial groups. In fact, 53% of these women were Caucasian, 32% were African American, and only 16% were Latina. In light of abundant research (with predominantly Caucasian samples) on the relationship between emotion regulation and eating disorder symptoms, the minority women were less likely to identify this relationship as a significant piece of their narratives. Rather, they were more likely to identify specific events or relationships, rather than feelings, which influenced their understanding of the illness.

*Feeling out of control.* A third individual component that consistently emerged from the women's stories about their eating disorders was feeling as though they had little or no control of their environments. Thus, they perceived their eating disorders as providing a deceptive outlet for control. Overall, 58% of the women explicitly remarked about their desire for control, and of these women, over half identified their home environments as being the most out-of-control context in their lives. The women talked about having no control over their parents' physical and/or emotional engagement in their lives, their parents' conflicted relationships, what and how much they were allowed to eat in the presence of other family members, and physical and sexual abuse. In response to these stressful conditions, controlling their caloric intake ostensibly created choices where there were none, provided independence when they felt smothered, and earned their parents' attention when they felt ignored. Anne (C) described how her eating disorder provided a mechanism of control in seeking the ideal relationship with her parents:

It is a control thing when you look at it that way because I was very deliberately trying to get them to do certain things, I think...I wanted them to show they cared

in certain ways and they never did those things. That was always just devastating to me.

Cara (C) echoed a similar sentiment in that her eating disorder controlled her “parents’ attention, a little.” From another angle, Sophia (L), who grew up in a very conservative family dominated by their religion, spoke of how her eating disorder helped her feel in control and independent when so many other choices were made for her by their religion, “I was trying to rebel. I felt like it was a really controlling religion and I wanted to like control something. I think that’s kind of why I cut and I purged because I wanted control.”

Childhood physical and sexual abuse was also cited as a reason for why the women felt as though they had little control in their lives. Nearly one quarter of the women recounted various incidents of physical and/or sexual abuse (half of whom experienced both physical and sexual abuse). Of these women, 63% were victims of physical abuse, perpetrated by their fathers (50%), boyfriends (33%), and caregiver (17%); one woman was not directly victimized but observed physical violence between two close family members with whom she lived.

While the number of women affected by physical abuse was relatively small in this sample, their accounts of these experiences were very significant to their stories about bulimia. For example, Amber (C) recalled “getting kicked, grabbing hair, shoving into walls and just...[my dad’s] a big guy.” She then went on to describe how she made sense of her bulimia, using catchwords like “power” and “cycle” that are so often associated with abuse:

Control, [the eating disorder’s] all about control. It’s like the one thing in my life where there’s nothing... Well, first of all, it doesn’t talk back to me, it doesn’t...it doesn’t ask me to fix it. It doesn’t tell me that I’m broken, it’s not alive. I mean,

I'm in complete control of it. It's a total power thing, it is a complete power thing...it's this whole dynamic and this whole cycle and it's this vicious cycle. And then that cycle in itself makes you feel even more powerless, which then fuels the fire.

Lauren (A) found herself trapped in an abusive relationship with a man who took advantage of her physically, emotionally, and sexually. She, too, spoke of the controlling cycle of abuse:

I couldn't get rid of him because it's almost like your father, like that first guy you just want his attention. You think the next time it will be different and it never is and it's almost insane because you're doing the same exact thing but you're expecting a different response and it's just, it will never work.

Lastly, Mya (L) recounted with teary eyes moments from her childhood when she was powerless and unable to control her environment:

[My dad] would pull our hair or something and be like, 'You're talking back'...and he used to stand in the part of the hallway in order for me to go to my room and I remember sometimes he would just kick me and it was just that dread of just having to be by him and that's why I'm saying I really grew to hate him. How can you just do that to your daughter? How do you do that? It was very much like I had no control over anything, nothing.

Mya went on to explain her eating disorder as being related to "not having control growing up of anything really...if I was thin then everything else will start to fall into place – my self-esteem, my relationship with my family, my relationships with other people."

In addition to being physically abused, nearly 20% of the women were sexually abused by various perpetrators, including a father, grandmother, boyfriend, cousin, family friends, and peers. While none of the women elaborated on the details or severity of the sexual abuse incidents (as to be expected from a one-time interview with a complete stranger), they did make it very clear that these experiences were traumatic and greatly shaped their experiences with bulimia. For example, Amber (C), who was raped

at age 10 by a friend's older sibling, noted, "So [the sexual abuse] definitely plays into....again, the control, major issues...I think it still plays that underlying role."

Similarly, Marissa (L) was abused at around age 2 or 3 by her cousin and grandmother and explained, "[The eating disorder] just has to do with my sexual abuse as a kid and self-medicate and the things that I do."

In spite of all of these women's attempts to use their eating disorders as a way to control their environments and relationships, they eventually found themselves prisoners of their eating disorders and once again feeling out of control. Lauren (A), who felt as though she used her eating disorder to control unfulfilling relationships with important men in her life, summed up this bittersweet dynamic:

It was control of everything, control to say that I'm going to eat what I want to eat and then get rid of it when I want to and I'm going to do it sometimes and not all the time, or that's what I would tell myself but then it was pretty much, I thought I had control of but you definitely don't.

As these passages demonstrate, the common denominator in all of the abused women's stories is the notion of control (or lack thereof). Pivotal moments from childhood, in which women were forced into subordinate roles and robbed of the right to control their lives and their bodies, eventually had profound effects as their lives became more complex and stressful. Their eating disorders seemingly developed as ways to regain this lost control – only they had the power to control what went in and what went out of their bodies.

### *Race-Specific Themes*

This section explores sociocultural and familial themes that emerged from only one or two of the racial groups, and not from the other(s).

### *Sociocultural Processes*

Specific to the minority participants, three themes emerged that were important in how they described their experiences with bulimia, which include: living in a bicultural context, cultural stigmas of bulimia, and cultural stigmas of mental health treatment.

*Bicultural context.* The issue of living in a bicultural context, in which women had to navigate two sets of cultural values and expectations, proved to be a very salient issue for 75% of the minority women, about half of the African American women and all of the Latina women; this issue did not emerge from any of the Caucasian women's narratives. An analysis by race and culture of these women's unique bicultural experiences revealed very different reasons for why this issue emerged as a salient theme. Thus, this section will first address the African American women's experiences, and then it will explore the Latina's experiences.

Of the 55% of African American women who spoke about the difficulties associated with navigating a bicultural context, two-thirds of them recalled painful memories of being teased for "acting white," and nearly all of them recounted moments when they truly wished they could just become a white girl; half of these women talked about experiencing both of these issues during their childhood and adolescent years. Getting teased for "acting white" was one way in which the African American women felt overwhelmed by trying to balance the larger, Caucasian culture in which they lived and the slightly smaller racial culture of their family and racial/cultural background. Both Wanda and Lauren remembered being called "Oreo" by the kids at school. When asked what it meant to be "white on the inside," Wanda explained:

I tried to get rid of any type of inflexions that might make me sound Southern or make me sound black...and we didn't look like anyone else in terms of the way that we dressed. I didn't want to, we went to go visit the relatives in the country

and I didn't want to get dirty with the other kids, I wanted to stay clean because my mom had me in a nice outfit. You know that kind of stuff...so it kind of distanced us, made us different.

She went on to explain how these supposed "white" qualities eventually earned her and her mom the derogatory title "seddity," which is used to describe an African American who is bourgeois and pretentious. Similarly, Lauren said that her nickname as an "Oreo" was used because she was well-educated and she participated in extracurricular activities, like 4-H. Additionally, Lynn was teased for being a "Becky" because she spoke proper English, she was animated, and she was very friendly; these qualities reminded her friends of a ditzy Caucasian girl in a scary movie "who trips and falls and who's like, 'Where's that sound coming from? Oh my god, what's going on?'" Thus, 'Becky,' a common Caucasian girls' name, was the term her friends used to capture this dichotomy of looking African American yet behaving like a Caucasian girl.

Being teased for acting white was difficult for these women because they certainly did not feel like they were being fake, and they often found this persona to be well-respected and valued when interacting with other people besides their peers. For example, Wanda learned from her mother that "this was the way to, for people to respect you, for you to succeed," and indeed she earned a great deal of respect from her teachers. These findings were further corroborated by the fact that over 80% of all the women who were picked on by their families for being overweight or too large were also minorities. While these families clearly had good intentions to "protect" their daughters from criticisms by the dominant Anglo culture, it also left the girls feeling caught "in the middle" and not quite sure how to navigate these two worlds, in which they could be Caucasian enough to fit in with the Caucasian kids and African American enough to fit in

with the African American kids. Thus, for many of these women, bulimia developed in a context of not fitting completely in with either racial group and not being able to please everyone. Modifying their appearances and losing weight would, in their minds, potentially move them one step closer to being able to fit in and be “more white.”

While all of the Latinas also spoke about their struggles with living in a bicultural environment, trying to be Caucasian was not their goal; rather, they were seeking to balance the acculturative stress after their families’ immigration to the U.S. and managing a healthy, thinner weight without sacrificing their culture’s calorie-dense foods. The acculturative stress, in which a person experiences emotional and psychological anxiety related to their immersion into a different culture, was cited by 73% of the Latinas and most commonly related to the generational differences between the more Americanized participants and their parents who were more deeply entrenched in the family’s own racial culture. Regardless of whether they were born in the U.S. or immigrated here during childhood, many of the women felt a cultural divide with their parents, both at home and at school. Mariana noted the change in her parents’ involvement at school after they moved to the U.S. from Guatemala when she was seven years old:

It was different when we came here because there are so many different cultures and my parents were a little bit more involved in school and stuff like that when we were in Guatemala because I guess they felt more comfortable and here it was a little bit, much more difficult for them to do it.

Celestine also recalled feeling different at school when the kids noticed how odd her lunch looked in comparison to their American-style lunch:

I would bring leftovers and it’s kind of like our lunch is kind of like our dinner meal, it’s the opposite really, and other kids would kind of look at me like, “Why don’t you have chips, a soda, and a sandwich? You have dinner food.”

For these women and their parents, being able to bridge the cultural divide would have made this transition seemingly easier and less stressful, and perhaps would have reduced their need to develop unhealthy coping mechanisms to manage their growing anxiety.

Secondly, 64% of the Latinas also spoke to their difficulties with wanting to eat the delicious, traditional foods prepared by their families, while also maintaining a healthy, slimmer figure. Eating when food was served, even when not hungry, and eating enough of what was served were typical family expectations voiced by many of the Latina participants. Madison, whose mother loves to bake cakes for any occasion, recalled people asking, “What happened?” and, “Are you mad?” when she didn’t eat everything served on her plate. Similarly, Celestine had a difficult time figuring out the right amount to eat, “Finishing up the plate is like a big thing...if I ate too much they had something to say, and if I didn’t eat enough they had something to say.” Mya captured the struggle she endured with her mother’s savory cooking, which plays an important role in her understanding of bulimia:

When I had that struggle, first started bulimia, I was back living at home. It was just that my mom would make all this food for me and I would feel guilty for being like, “Oh, mom, it’s good,” but then I’d go throw it up because I felt guilty because I don’t want to be as chubby or chunky. I’m trying to lose the weight but I still want to make you happy by eating the food that you make for me and I know that brings my mom happiness.

Maria also shared a similar sentiment with her battle to manage her grandmother’s high-carb cooking while still fitting into “this mold of being thin.”

In sum, when asked how they understood why their eating disorder developed, many of the minority women identified the stress surrounding their maturing racial identities and the disparate expectations of their sub-culture and the larger Anglo culture. However, the specifics of how this illness helped the African American women versus



the Latinas to cope were very different. For African American women, the eating disorder helped them find a way to fit in more with the Caucasian culture, since they felt so different and disconnected from other African American people. The Latinas, on the other hand, found the disorder to be useful in managing their anxiety related to either moving to the U.S. and/or negotiating cultural expectations with their parents who more closely adhered to the values of the family's own racial culture.

It is interesting to note that most of these discussions about racial identity were in the context of asking all of the women, "In thinking about the development of your eating disorder, how relevant is/was being a {participant's race} woman in your community?" Both the African American and Latina women provided very descriptive and thoughtful answers, as described above. However, when the Caucasian women were asked this question, most responses included a long pause followed by a hesitant answer such as, "I don't know" or "There was nothing about race." While some of them did go on to say that being a Caucasian woman just made it "easier" for them to have an eating disorder because it was more accepted, and others reiterated the massive amounts of media images they saw of thin, Caucasian women, very few explored in-depth how their experiences as a Caucasian woman ultimately played a role in their understanding of the illness.

*Cultural stigma of bulimia.* The issue of what it means to be an African American, Latina, or Caucasian woman with an eating disorder clearly influenced the women's decisions to share their experiences, and emerged as one of the most significant themes from this study. Data for this theme were primarily extracted from the women's answers to the question, "How has your eating disorder affected the way you think of yourself as a {participant's race} woman?" Similar to the responses from the Caucasian women when

asked how their racial identity may have influenced the development of their eating disorder, the majority of their responses to the former question were phrases like “I don’t think about it” or “I have no idea.” Again, the Caucasian women rarely emphasized the issue of being Caucasian as actually influencing their understanding of the eating disorder, as well as their decision whether or not to talk about it.

With that said, however, some of the Caucasian women did explore how the Caucasian culture’s passive acceptance of eating disorders made it more acceptable for them to reach out for help and access services. For example, Amber noted that her bulimia just made her “the classic white woman” who thinks she’s fat and ugly, and having an eating disorder seemed like a culturally-accepted way to “have that body” and “have that life.” Elizabeth simply felt like, “It’s more common than not for people to be worrying about their weight...particularly white women.” Emma perceived her eating disorder as fairly common because she “just blended in with the rest of them” and “fit the bill.” Finally, Page perceived her experience of being a Caucasian woman with an eating disorder:

It’s such a common problem. It’s become more of a public health issue that’s talked about or encouraged...as a white woman I don’t feel like there’s too much of a negative stigma because it’s a solution, it’s an active solution people use.

The Caucasian women’s consistent use of words like “common” and “classic” speak to the notion that bulimia, and possibly even all eating disorders, seem to be widely accepted, and possibly even expected, within this racial/cultural community.

This notion of bulimia as customary or ordinary within the Caucasian population is in stark contrast to over two-thirds of the minority women feeling as though they were “the only one” with bulimia. In spite of the fact that many of the African American

women and Latinas wanted to be thinner, they knew that that goal was “not culturally what [they] should want or what’s healthy” and that bulimia simply was not considered a problem in these communities, thus making it that much more difficult for the women to talk about the illness and seek treatment for it. For example, Lauren (A) feared that if she told her family about bulimia, then they might think that she was just trying to be Caucasian and associate with that race/culture, “There’s no way an African American girl could do that. Even if you do that you’re never going to be like that so there’s no, it’s futile.” Additionally, Sophia (L) shared why she felt so stigmatized and silenced by her culture:

Sometimes the natural, bodacious figure seen in Latinas is celebrated by the media and I may be confronted with questions such as, “Why would you wanna? You have a beautiful body.” They’re kind of proud of their body figure and they would be like, “Why would you wanna ruin that nice, curvy body for this Americanized stick figure?”

As a result of this stigma, Mariana (L) considered herself to be “just another Latina woman that had to hide it” and Wanda (A) found herself wondering why she could not just “get over” her problem with “self-control.”

*Cultural stigma of treatment.* In conjunction with the cultural stigma of having an eating disorder, many of the minority women also felt as though accessing treatment for their eating disorder was culturally unacceptable. In fact, although nearly two-thirds of the sample sought some form of professional treatment for their eating disorder, only half of these women were African American and Latina (evenly divided by both races), suggesting that the Caucasian women were twice as likely to receive treatment for bulimia than the minority women. Furthermore, of the minority women who did seek treatment, they were often the “token minority.” For example, Kayla (L) wanted to attend

a support group in college but felt like she could not explore issues related to being a Latina with an eating disorder because the group was “predominantly Caucasian,” and Wanda (A) shared her frustration with being the only minority woman at eating disorder support groups and community events.

Except for pharmacological treatment, in which one woman from each racial group took medication to control their eating disorder symptoms, the Caucasian women were significantly more likely than their minority counterparts to participate in all other forms of treatment. With respect to hospitalization/in-patient/intensive outpatient therapy, in which a person lives in a treatment facility or commutes there daily for several hours of treatment, 89% of the women were Caucasian, and the remaining 11% were African American; no Latinas sought this intensive form of therapy. Nearly half of the women who sought outpatient individual therapy were Caucasian, and the remaining half were divided by Latinas (30%) and African American (20%) women. Of the eight women who regularly attended community support groups, which are often free and open to the public, 50% were Caucasian, 38% were African American, and 12% were Latina. Most notably, particularly given the focus of this study, nutrition counseling and family therapy were *only* sought out by Caucasian women and their families; no minority participants used these services to treat their eating disorders.

One theme that consistently emerged from the minority women’s narratives as to why they opted to not seek professional treatment for their eating disorder was the cultural stigma surrounding mental health disorders and treatment for these disorders. Similar to the phenomenon of minority women talking about feeling like “the only one” with an eating disorder, they were also alone in their feelings of being stigmatized for

seeking treatment; this did not emerge as a salient concern for Caucasian women. According to 64% of the minority participants, this stigma existed in part because of three culture-specific reasons: (1) minorities who go outside of the family for help are looked down upon and often considered “crazy;” (2) minorities are faced with so many challenges just to survive, and so mental health treatment is an unnecessary luxury; and (3) there are very few mental health professionals of color who can relate to the sociocultural experiences (e.g., racism, bicultural context) of these women and families.

Being labeled “crazy” for stepping outside the family boundaries in an effort to get help for their eating disorders was a real concern for many of the minority women. While this issue persists in most cultures, including the Anglo American culture, it seemed particularly powerful for the minority women and was enough to prevent many of them from actually seeking help. For example, Nicole (A) described her perception of the stigma in the African American community, “They don’t want any therapy because they think that you’re crazy if you go to therapy.” Additionally, Celestine (L) described the Latin culture’s stigma surrounding therapy, “They look at it as something like a witchcraft type of thing.” Clearly, the perception of somebody asking for help in these cultures carries a very negative connotation, and eventually convinced these women to make sure their eating disorders remained “an internal issue.”

Secondly, some of the African American women spoke to the historical context of their culture’s stigma, in which the ongoing struggle to simply survive negates the opportunity to indulge in the extravagance of therapy. Lynn (A), a single mother whose family has stressed over finances since her early childhood years, explained her perception of the African American cultural stigma:

Within the African American culture, period, we just don't really look at psychologically emotional disorders as being something that's valid and the reasons why are because so many African Americans struggle with just the basics, just getting by – having food, having shelter – that those other things are past secondary, they're just unheard of.

Wanda (A), who was adopted at birth and raised by a single-mother after her father left the family, expanded this cultural context of the stigma with her understanding of how mental health treatment is perceived in the African American community:

Mental health is not really something that's discussed in African American families; that's something that Caucasian families deal with because they don't have anything better to do with their lives. We've had to struggle through the Civil Rights Movement...I think in the culture there's this real sense that our parents sacrificed a lot. Our parents went through the hard struggles and they did so that we can, people in my generation, can be better off...it's like, "What do you have to complain about? Why do you have to be depressed? You've had everything; I've given you everything."

This powerful reminder of how the African American culture was developed and the reverberations of slavery and racism that persist today is a critical element to consider when understanding why some women and families were more likely than others to seek mental health services.

A third component of the cultural stigma that was addressed by many of the African American women and Latinas is the lack of minority professionals who can provide culturally competent therapy services to treat eating disorders. Often times, the women were unfamiliar with any clinics or practices that served the needs of minorities with eating disorders, and the services that they were able to access were offered by predominantly Caucasian professionals in upper-middle class suburban environments. Furthermore, when specifically asked during the interview, "Did the treatment explore how your racial background may have influenced your eating disorder?", only 18% of the minority women who sought treatment affirmatively answered that, in fact, they had

discussed issues of race, culture, and discrimination with respect to their eating disorders. Furthermore, in spite of this strong cultural stigma against mental health treatment, many of the women said that they would be amenable to seeking help if culturally sensitive services were available. For example, Nicole (A) recounted how she wished that she could have worked with a therapist of color to help her understand how her family's alcoholism and depression was likely rooted in earlier generations' struggles to simply survive as African American people in the U.S., "I think that a multicultural counselor could have put a lot of those things in perspective...[they] could have steered me in some of those directions and how to manage those feelings."

### *Family Processes*

*Effective family communication.* In spite of the majority of women from all three racial groups who described their families as having unhealthy and destructive patterns of communication (as noted in the previous section), one quarter of the women did report having an overall level of open, healthy communication with their families during childhood. Of most interest, 75% of these families were African American and the remaining 25% were Latina; no Caucasian women identified their families as having a general atmosphere of healthy communication prior to the start of her illness. For example, Nicole (A), who grew up with her mom and sisters, exemplified her family's healthy communication during two pivotal moments in her life, her parents' divorce at age nine and then puberty during adolescence:

We all went to therapy when they first got divorced to explain, "This is what's happening, it's not your fault," and all these things, which are good when you are young...[my mom] would have these little talks with these like, "So how do you feel?"...she was very, very open going through puberty and stuff, sit you down, have the talk, like, "Do you know what's happening to your body?...Do you know what this means? You know you'll be able to conceive a child." I was like,

“What? Are you joking? I want to go to recess!”...she was just like, everything is on the table.

Debra (A), who grew up with her parents, older siblings, and twin sister, also remembered having a mom who encouraged open communication, even during the uncomfortable adolescent years:

My mom took seven years of psychology in college so she rarely raises her voice...my mom always wanted to talk everything out...and it used to piss me off because I would want to stay mad but she always knew how to calm me down.

The women who grew up in families with constructive communication skills felt like they could talk to their moms about most anything, like Lisa (A), who lived with her parents and older sister, who described her mom as providing for all her daughters' needed and being available to talk with Lisa about whatever was on her mind. Once again, these findings are most interesting when situated in the context of the African American women also reporting having the closest relationships with their mothers and siblings, as compared to the Caucasian women and Latinas.

*Familial misunderstandings of bulimia.* Of the women who chose to not tell their families about bulimia, half of the minority women worried that their families would completely misunderstand their eating disorder and be dismissive of their experiences as a minority woman with an eating disorder because “that is not one of our issues.” Both the African American and Latina women consistently talked about how their families would not “even know what to do with it” because “it’s not something that you think is going to come up in a [minority] household.” While this belief is likely couched in the context of the aforementioned cultural stigma surrounding eating disorders, the minority women felt particularly stifled by their own family’s inability to conceptualize and understand something that was seemingly foreign to their cultural community. For



example, Nicole (A), hypothesized how her extended family might have responded if they learned of her eating disorder, “[They] would’ve been like, ‘She just wants attention’ or ‘She’s acting out’ or being ‘spoiled,’ because you can’t really have an issue with your body. Like I said, my family would be like, ‘You the smallest one!’”

### *Individual Psychological Processes*

*Conflicted racial identity.* In addition to the African American women’s experiences of living in a bicultural context, in which they were teased for *acting* white, over half of them also recalled wanting to actually *be* white. These women desired to be more accepted by their Caucasian peers, to be considered beautiful, and to be favored like Caucasian people; they struggled with developing a racial identity that incorporated the demands of the larger, Caucasian culture, with the values and beliefs of their racial culture. This phenomenon is not surprising given that only 12% of the African American women grew up in all-black communities, where there were very few or no Caucasian residents. Thus, over 80% of the African American women grew up in either all-white (35%) or diverse (45%) communities, in which they were frequently exposed to messages about the dominant Anglo culture and encouraged to identify themselves in such a way. For example, Debra grew up in a racially diverse community and as she entered puberty and felt uncomfortable in her changing body, she recalled thinking, “White has always been the standard of beauty. I just remember wanting my hair lighter, wanting my eyes lighter, wanting my skin lighter. I wanted to be skinnier, straighter hair.” Furthermore, Lauren also grew up in a racially mixed neighborhood and she recalled wanting to be Caucasian so as to know what it felt like to be afforded privileges, “Even though I had this outward hatred of white people and hatred of the system and hatred of this oppressive

nature of society in general, I really internalized that desire to be not just accepted, but favored.” Thus, as these women exemplify, the integration of values and beliefs from the dominant culture into their identities as African American women proved to be a challenge that manifested in a much more personal and complex way.

### Conclusion

From this data emerged a holistic understanding of how African American, Latina, and Caucasian women’s experiences of bulimia are both similar and racially/culturally unique. Common experiences for many of the women, regardless of race, included sociocultural pressure to look a certain way and fit in with other girls; family processes that included poor communication, strained relationships, and emphasis on members’ outward appearances; and individual management of other psychological disorders and emotions. Unique issues related to both African American women’s and Latinas’ experiences with bulimia included living in a bicultural context with cultural and familial stigmas surrounding mental health. Additionally, African American women reported overall healthier family environments, in which they had supportive relationships and effective, open communication.

## CHAPTER 5: DISCUSSION

Qualitative research results should provide new insight into a significant family issue and/or a population that is often ignored in scholarly literature (Ambert et al., 1995). While the issue of families affected by eating disorders has become a popular focus of research, the voices of women and families from diverse backgrounds affected by these illnesses continue to be excluded. Furthermore, efforts to develop culturally sensitive treatment models for minority women and their families dealing with eating disorders remain disgracefully sparse. Thus, the purpose of this study was to explore how African American, Latina, and Caucasian women experience bulimia in relation to their racial/cultural and familial contexts. Findings from this study can be used to better understand the multicultural facets of this illness and eventually devise culturally competent therapy models for women with bulimia and their families.

In this chapter, a brief review of the study's limitations is presented so that the subsequent sections can be considered in light of these few shortcomings. Then, the major research findings are summarized, followed by a theory-based discussion of four of the study's major contributions. Finally, the study's strengths are explored; and research, policy, and programmatic implications are considered.

### Limitations

The primary limitation of this qualitative design is that I was the sole researcher conducting the interviews and interpreting the data. My personal biases inherently affected how the interviews were administered (e.g., empathy for participants, unplanned follow-up questions), and how "emergent" themes were identified and organized. As a

result, it is likely that different researchers would generate different responses from the participants, as well as different results from the data.

A second limitation to the current study is the use of women's retrospective accounts of their childhoods, since at the time of the interview many of them were young adults living on their own. It is possible that the women's memories may have become distorted over time. For example, perhaps some women focused on the negative aspects of their childhoods, and misrepresented the proportion of positive memories. Or, it is also possible that as time passes, some women have forgotten how strained their home environments actually were at the time, and they have since developed a more positive recollection of their childhood. However, in light of this limitation, using retrospective data may be beneficial in that young adult women are better able to provide a more balanced, realistic perspective of their home environment, while also reflecting on more abstract concepts such as racial identity and recovery, which may have been less developed during their adolescent years. Furthermore, use of retrospective data in this study was well aligned with the principles of feminist theory, in which women's narratives and perspectives were valued and used as the primary source of data.

Third, in an effort to study between-group differences among African American, Latina, and Caucasian women, the present study grouped all Latinas together even though they collectively represented seven countries. As a result, some within-group differences among the Mexican American, Central American, and South American participants may have been overlooked during the analyses for this dissertation.

Finally, the current study is limited in its generalizability to all women who have experienced bulimia. Unique to this study is the way in which women were recruited,

such that the sample represents a wide range of women from very diverse backgrounds (e.g., socioeconomic status, country of origin, level of education), yet it is important to remember that all of the women self-selected themselves into the study. Thus, it is likely that women further along in their recovery may have been more inclined to share their story, as opposed to women entrenched in the illness and unable to describe their experiences of having bulimia. Additionally, due to frequent skepticism or mistrust of the ivory tower among some minorities, particularly African Americans (Wasserman, Flannery, & Clair, 2007), it is plausible that not all minority women who read the advertisement for the study and qualified actually initiated contact with me. Perhaps this sample represents a more educated group of women who appreciate the value of research, were willing to reveal personal information about themselves in an effort to help the eating disorder community, and felt comfortable working with a Caucasian researcher.

#### Summary of Major Research Findings

To better understand how women from diverse backgrounds described their experiences with bulimia, findings at the sociocultural, familial, and individual levels were organized into two groups: themes that were fairly universal across the women's narratives, and themes that were more unique to only one or two of the racial groups. Close examination of these similarities and differences among African American, Latina, and Caucasian women's experiences with bulimia provided insight into how this illness unfolds in different racial, cultural, and familial contexts. It also shed new light on how existing theoretical frameworks are useful in understanding many aspects of bulimia, and at times limited in their abilities to make sense of minority women's experiences with this illness.

The majority of significant experiences that were related to the women's understanding of their bulimia were fairly universal across all three racial groups. Socioculturally, all of the women internalized the Anglo culture's message that thinness equates success and power, although the degree of desired thinness somewhat varied across the racial groups. Often times these messages about body shape and size were conveyed to the women through participation in image-conscious sports, such as dance and gymnastics. These findings are consistent with previous research in which African American and Latina women desire slightly curvier and more voluptuous bodies that are "not too thin," as compared to their Caucasian counterparts who place no limit on their desired thinness (Bay-Cheng et al., 2002; Duke, 2000; Miller et al., 2000; Schooler et al., 2004). However, as previous research has also supported (Akan & Grilo, 1995), the minority women in this study often experienced teasing related to their bodies and cultural pressures to assimilate into the dominant Anglo culture, and so many of them sought thinner bodies than other women from their racial/cultural group. Women from all three racial groups also spoke of an implicit "girl competition" between themselves and other women in which they strived to be perceived as more attractive and, at times, thinner than other women; they rarely spoke of a desire to be beautiful in an effort to impress men or significant others.

The majority of women in the present study spoke of troubled home environments, which were often riddled with poor communication and tense relationships. Most commonly, the women noted how their families only talked about superficial topics related to day-to-day activities. In an effort to avoid conflict, families rarely talked about anything under the surface level, especially when it involved the

eating disorder. Associated with this lack of communication was the number of strained parent-child relationships, which were described as having shallow communication, scant emotional support, limited parental guidance, and inappropriate boundaries. Furthermore, more than half of the women described their parents' relationship with each other as troubled and conflicted. As a result of the poor communication and tense relationships among members, the women's decision of whether or not tell their families about the eating disorder proved to be a difficult one. Eventually, the majority of women shared their secret with a parent, however most of them felt unsupported due to the lack of open communication about the illness and the intense monitoring of their eating and restroom activities. All of these family-related processes are consistent with previous research on families affected by eating disorders, characterized by low levels of cohesion, adaptability, organization, and expressiveness (Breiner, 2003; Haworth-Hoepfner, 2000; Wisotsky et al., 2003). As these findings suggest, the women desired more cohesive relationships with their families; they yearned for their families' flexibility in managing the illness; and they wished for more open communication among members.

In addition to external processes that many of the women experienced, there were also some individual processes that were relatively universal across all three racial groups. The abundance of research on comorbid mental health illnesses associated with eating disorders (Kendler et al., 2001; Pike et al., 2001; Striegel-Moore et al., 1986) supports findings from this study, in which over three-quarters of the women also experienced troubling symptoms associated with other mental disorders, most notably depression, anxiety, and obsessive-compulsive disorder. Furthermore, over half of the

women spoke of using their eating disorder as a way to manage difficult emotions, such as fear and loneliness, and/or to help them feel in control of their lives.

In addition to many universal themes that emerged across racial groups, there were also unique experiences only spoken about by one or both of the minority groups. Each of these themes, along with one universal theme, are discussed in more detail in the next section as they are unique contributions to existing literature on eating disorders. At this point, the findings will simply be briefly summarized. Socioculturally, both the African American women and Latinas spoke at great lengths about their experiences of living in a bicultural context, in which they felt a culture clash in values and beliefs between their racial culture and the larger Anglo culture. Being teased for their skin color, “white” mannerisms, and naturally curvy body shapes were common experiences for these women, which then amplified their efforts to assimilate into the dominant culture. For these women, bulimia became a “creative coping strategy” (Thompson, 1992) to help them navigate these conflicting worlds.

The cultural and familial stigmas of having bulimia and seeking mental health treatment also emerged from the majority of minority women’s narratives in relation to their experiences of being a woman of color with an eating disorder. Both the African American women and Latinas felt alone in their struggles because of cultural stigmas associated with eating disorders, such as being labeled “crazy.” Additional processes contributing to this feeling of being alone were a cultural reluctance for seeking help outside of the family, as well as their families’ beliefs that bulimia is not a legitimate illness. This finding supports previous research on families affected by eating disorders, in which many of the patients perceive their families as unsupportive and not trustworthy



(Kog & Vandereycken, 1989; Striegel-Moore et al., 1986). However, this study adds to the research because it contextualizes this experience for minority women and helps to explain *why* the women may have felt this way about their families. It strengthens feminists' assertion that parents and families are managing these illnesses in the context of a very oppressive and unhealthy society that designates eating disorders as taboo and expects women to manage their problems without professional support (Maine, 2006). This finding was further exemplified in the percentage of women who sought treatment – the Caucasian women were two times more likely than the African American women and Latinas to receive professional help for their bulimia.

#### Theoretical Analysis of Major Contributions

While not all findings from the present study can be discussed in detail, this section expounds upon four emergent themes that are major contributions to the current understanding of women's experiences with bulimia. These findings were deemed particularly noteworthy for one of two reasons – they expose racial/cultural nuances in women's experiences with bulimia that have yet to be explored in eating disorder research, or they contrast previous research outcomes. The larger goal of this section is to examine these four findings in the context of feminist and family systems theories, which have been used in previous research to explain eating disorders and were also used as guides to develop the original interview questions for this study. The four themes are the comparison of physical appearance to other women, cultural underpinnings of bulimia, supportive nature of African American families, and family support after revealing bulimia.

### *Comparison to Other Women*

This emergent theme of women comparing their bodies to other women's bodies was common to many of the narratives, regardless of race. Time and time again, the participants noted their intense desires to look as good as, if not better than, their female friends, schoolmates, and other women around them. They recalled wanting to be "looked at" and deemed popular or acceptable like the other thin women around them. Initially, this theme did not strike me as significant since wanting to be thin is usually a core component of many eating disorders. However, further consideration shed light on what the women were *not* saying during their descriptions of this "girl competition" – seeking the attention of men did not seem to drive this as much as women trying to be better than other women. Thus, the importance of this finding is not so much that the women wanted to be thin and considered attractive, since that is presupposed when working with people experiencing bulimia, but whom they considered to be the judges of this competition. For these women, the internalized message of "thin is in" had somehow manifested into a competition in which women were both the participants and the judges.

This finding challenges the existing feminist literature on women's body image and eating disorders because it calls into question the degree to which the principles of feminist *theory* are aligned with the principles of feminist *research*. According to feminist theory, being a fat woman has been defined by men as shameful and weak, and in response women have starved fat off their bodies in an attempt to be deemed worthwhile and beautiful in this patriarchal culture (Wooley, 1994). However, findings from the current study do not necessarily support this theory; the participants did not trace these messages back to men. Rather, they spoke of the internalized benchmarks set by themselves, which were then used to compare and contrast their own thinness against

other women's bodies. This discrepancy in theory versus research questions who really sets the standards for women and then judges them accordingly.

The challenge of this finding is to determine how these women's "truths" can be preserved within the context of a theory that seemingly advocates for another truth. In keeping with the principles of feminist *research*, it is important to highlight how these women described their experiences, not how theorists and researchers interpret them. As the participants described, this competitive culture among women is truly a product of the standards they set for each other, and not necessarily an outgrowth of men's expectations. However, using feminist *theory*, it is certainly possible that these women just were not mindful of the larger context in which this competition festered, a context dictated by male desires and expectations. Perhaps a more in-depth exploration with the participants would have generated insight into how our patriarchal culture has influenced women's intense focus on looking better than other women. Thus, given that both of these arguments seem plausible, it is clear that further investigation of this topic is warranted to truly understand how women's experiences and theoretical interpretations of these experiences are aligned. A solid understanding of this intersection will create a foundation on which in-depth research can be conducted to further investigate this phenomenon.

### *Bi-Cultural Underpinnings of Bulimia*

Another uniquely significant finding that emerged from the current study is the bi-cultural experience of minority women affected by bulimia. This finding is a useful addition to the current literature on eating disorders because it casts doubt on the idea that eating disorders are simply manifestations of a culture obsessed with thinness, and

provides further support that treatment protocols must be tailored to address the racial idiosyncrasies of people's physical and emotional experiences with bulimia.

The African American women spoke very openly about being caught in a bicultural context with clashing values and expectations. They felt unsuccessful in their efforts to be "white enough" so as to reap the privileges and benefits of being a person of the dominant race, and then these efforts compromised their abilities to also be considered "black enough" to socialize with the African American kids at school and in their communities. This emotional tug-of-war of trying to fit in with both cultures left the women feeling as though they did not quite identify with either group, which then led to feelings of loneliness and frustration. This finding supports previous research on eating disorders and African American women, which has suggested that bulimia does not necessarily serve the purpose of achieving a thin body simply because the women consider that attractive, but it serves the purpose of moving these women one step closer to fitting in with the expectations of the dominant Anglo culture that values thinness, and ultimately equates this body image with success and superiority (Schooler et al., 2004). Thus, for these women, living in a culture that valued thinness did not necessarily lead to the internalization of desiring a thin body, but it led to a cultural clash of norms and demands that were terribly confusing and chaotic.

Unique to the bicultural experiences for some of the African American participants was the inextricable link between their sociocultural process of trying to fit into two cultures and their individual psychological process of having a conflicted racial identity. For these women, wanting to actually *be* white was an extreme manifestation of their experiences of being teased for *acting* white or not feeling black enough. They went

above and beyond just trying to fit in with their Caucasian peers and be considered beautiful, and truly internalized the demands, values, and beliefs of the larger, Caucasian culture into their identity as an African American woman. Thus, while their “conflicted racial identity” was written about separately as an individual psychological process experienced by some of the African American participants, it is important to highlight that this personal experience was actually an extreme aspect of the larger sociocultural phenomenon experienced by so many of the minority participants.

A somewhat different cultural experience emerged for the Latinas, in which they vacillated between wanting to enjoy the culinary traditions of their families’ culture, while still maintaining a slim figure in keeping with the larger Caucasian standard. For these women, bulimia seemed like the “best of both worlds,” a practical solution, because they could honor the Latin cultural tradition of nurturing familial relationships through the sharing of high-calorie, fattening foods, and then compensate so as not to endure the physical consequences. This experience is slightly different from the African American women because bulimia does not seem to represent the same degree of internalized racial and cultural conflict. While the African American women battled with the emotional strife of trying to fit into two different cultures, the Latinas aimed to appease their families by eating, but then ultimately sought to assimilate into the cultural values of the dominant Anglo culture; this process of navigating two clashing cultures did not seem to be as emotionally strenuous for the Latinas as it was for the African Americans.

These experiences of the minority women are in contrast to the Caucasian women’s understanding of how race influenced their experiences with bulimia, in which they confirmed previous research on the internalization of this drive for thinness that is

set forth by the dominant Anglo culture (Marx, 2000; Petersons et al., 2000; Sorbara & Geliebter, 2002). They understood and internalized the inextricable link between thinness, beauty, and success, and used bulimia as a means by which they sought this ideal body image. These racial differences with respect to the function of the eating disorder are further corroborated by the fact that over half of the Caucasian women battled anorexia prior to developing bulimia, in which they restricted food in an effort to control their weight and be thin, but then developed bulimia because self-starvation was simply too difficult to maintain; in contrast, only about 20% of the minority women dealt with anorexia prior to bulimia, suggesting that minorities' experiences with bulimia are not necessarily rooted as deeply in this intense drive for thinness.

A feminist interpretation is useful in understanding how these women followed different cultural paths to the same illness. Thompson (1994b) posits that the feminist model is effective in conceptualizing eating disorders as creative coping strategies for various traumas, particularly for women from diverse racial/cultural backgrounds. For the minority women in the present study, their traumas included cultural clashes in gendered values and expectations, experiences of cultural marginalization, and efforts to create an identity amidst confusion and rejection – any of these stressful experiences may have required coping skills that manifested through their bulimia. Furthermore, a feminist framework weakens the argument that eating disorders are solely rooted in a drive for thinness and that minority women are protected from eating disorders. Rather, while minority women may not necessarily desire to be as thin as Caucasian women or even consider thin bodies to be beautiful, they still internalize the gendered expectations of women and seek to assimilate with the dominant culture. Consequently, these oppressive

experiences generate uncertainty and anxiety due to the conflicting and ambiguous nature of the bicultural values and roles (Harris & Kuba, 1997; Kuba & Harris, 2001; Petersons et al., 2000), which then leaves the women vacillating between the disparate expectations of the cultures, represented by the vacillation in their relationship with food.

Much like the previous finding on supportive families, feminist theory enhanced with culturally sensitive theories and models provides a more holistic explanatory framework for understanding minority women's bicultural struggles. Womanist (Walker, 1983) and Latina feminist (Comas-Diaz, 1988) theories complement general feminist theory by considering the compound effects of sexism and racism when trying to understand minority women's bicultural experiences. Additionally, Helms' (1995) model of Black racial identity supplements general feminist theory by providing racially sensitive insight into the unique struggles of women of color affected by bulimia, such that bulimia may be symbolic of their fluctuations through the four stages of racial identity development. As the women internalize the clashing expectations of both the African American and dominant Anglo cultures, they grapple with internalized racism and creating an identity that healthily incorporates values from both cultures. In this model, African American women (and possibly other minorities) move back and forth through four stages: (1) Preencounter, in which they perceive Caucasians and the dominant Anglo culture as superior; (2) Encounter, which is characterized by confusion with regard to how to understand the culture clash; (3) Immersion/emersion, in which they idealize being African American and reject Caucasian qualities; and (4) Internalization, in which they elevate the African American culture as their primary cultural reference, while incorporating components of the larger culture that may, at

times, clash with their primary reference group. While the women in the present study did not explicitly classify their experiences using this framework, an interpretation of their narratives suggests that they certainly grappled with all four of these stages – they recalled times in which they wanted to be white and considered that lifestyle superior (preencounter), there were times when they were unsure of how to be considered black enough and/or white enough (encounter), they expounded upon moments when they hated white people (immersion/emersion), and many of them also spoke to the clarity they now have about how to navigate these two worlds (internalization).

For the purposes of the present study, in which sexism and racism are analyzed concurrently, it is interesting to hypothesize how this model of racial identity may also be applied to women's gender identity development within a patriarchal culture. Perhaps women first accept that men are deemed more powerful than women (preencounter), and then they become confused as to whether or not they truly agree with this patriarchal chain of command (encounter). Then, some women may idealize being a woman and outwardly downplay or reject the positive qualities of men (immersion/emersion). Finally, women embody their female identity and use it as their primary cultural reference within the context of the larger patriarchal culture, understanding that these two cultures may not always coincide (internalization). Using the framework of womanist (Walker, 1983) and Latina feminist (Comas-Diaz, 1988) theories, in which women's experiences with sexism and racism are considered simultaneously, it seems plausible that a complementary framework considerate of racial *and* gender identity development in understanding minority women's experiences with eating disorders would also be useful in providing a more holistic interpretation of these illnesses in diverse populations.



As these race- and culture-based frameworks demonstrate, consideration of the differences in African American, Latina, and Caucasian women's experiences with bulimia enrich our understanding of these illnesses beyond the feminist principles of patriarchy and gender-based stressors. A marriage of these models, which shows how illnesses that are seemingly alike on the surface level can actually be quite different for women immersed in different racial/cultural contexts, needs to become a part of the dominant discourse on eating disorders so as to advance our cultural knowledge of and sensitivity to the diversity in people's experiences.

#### *African American Families*

The most noteworthy finding of the present study is the deconstruction of familial pathology in African American family relationships before and during the women's experiences with bulimia. In spite of the fact that the African American women reported the most emotionally and physically distant relationships with their fathers, they also reported the greatest amount of cohesive, nurturing relationships with their mothers and siblings, as well as the greatest amount of healthy, direct communication between family members. It should be noted that while only one-quarter of all women participating in the study described their families as having healthy levels of open communication, nearly all of these women were African American. Thus, in spite of the strained relationships with their fathers, the women still felt cared for and supported by their mothers and siblings (who often played the role of second mothers), and were more likely to communicate well with their families than Latinas and Caucasian women.

This finding is a unique contribution to the current field of research on eating disorders for many reasons. First, it sheds new light on the experiences of African

American women affected by bulimia and their families. Even as the number of studies investigating minorities' experiences with eating disorders steadily blossoms, few studies explore these experiences in the context of the family, and thus little understanding of the minority family environment is known in relation to their experiences with eating disorders. Second, this finding contrasts the two quantitative studies that most closely resemble the current study, in which no significant differences were found among African American, Latino, and Caucasian families' overall interaction patterns, levels of satisfaction, and levels of cohesion and adaptability (Hoste et al., 2007; Rorty et al., 2000). Third, this finding provides powerful evidence against the traditional "mother-blaming" that continues to permeate the eating disorder community and the larger mental health field. The remainder of this section will interpret these findings using feminist and family systems theory, and will further draw on principles from womanist theory (Walker, 1983) and the African worldview (Randolph & Koblinsky, 2003) to provide a more culturally sensitive framework.

This finding of closeness to mothers is consistent with feminist theory, which emphasizes a "mother-affirming" approach and honors the positive qualities of mother-daughter relationships (Rabinor, 1994). Traditionally, the mental health field has blamed mothers for their children's illnesses, from schizophrenia to eating disorders, and so pathology in the mother-daughter relationships is virtually expected. In fact, during the 1970s and 80s, poor mothering was overwhelmingly cited in research studies as a primary reason for daughters' disordered eating (Wylie, 1989), and many clinicians advocated for in-patient treatment that banned daughters from having contact with their mothers while receiving services. However, as this current finding illustrates, mother-

daughter relationships are not always riddled with strife, and certainly cannot be targeted as universal culprits of eating disorders. The African American women in this study spoke very highly of their mothers, and considered these healthy relationships to play an integral role in their abilities to confront their disorder. Moreover, this finding lends evidence to feminists' belief that mothers should be utilized as a valuable tool in their daughters' recovery, rather than excluded from the process and made to feel guilty and powerless. By doing this, the inherent bond between a mother and daughter is validated, and emphasis is placed on relationship strengths, rather than deficits (Rabinor, 1994).

Further application of this theory, in tandem with womanist theory (Walker, 1983), seems to elucidate how and why the experiences of African Americans were different from their Latina and Caucasian counterparts. As womanist theory posits, African American women share a unique bond in their experiences with both sexism *and* racism, and the African American women in this study seemed to experience and perceive the greatest amount of sociocultural oppression (and consequently the least amount of control and power) among the three racial groups. Unlike other women (particularly Caucasians) who may be less likely to experience racism, and men who cannot fully understand women's experiences with sexism, African American women in this study were subject to both forms of discrimination, which created a distinct and unifying experience for them; this experience certainly was not as intense, or even present, among the other cultural groups. Consequently, the unique cultural context of African American women leads them to rely more on other African American women (i.e., mothers, parentified sisters) who can empathize with their experiences and provide comfort when challenged with these social and institutional injustices. This consideration

of sexism and racism provides a more holistic interpretation of the increased levels of cohesion and healthy communication among these families.

One tangential finding that is interesting to note with respect to racial differences in mother-daughter relationships is the percentage of women from each group who reported strained versus healthy relationships. As noted, less than half of the African American women described strained mother-daughter relationships, about two-thirds of the Latinas described difficult relationships with their moms, and nearly all of the Caucasian women reported strained relationships. Feminists' assertion that "mother-blaming" is a cultural phenomenon developed and exacerbated by the mental health field (Rabinor, 1994) leads me to question the degree to which these relationships actually *are* strained, or if cultural interpretations have simply identified and labeled these relationships in such a way. It does not seem coincidental to me that of the three racial groups, the Caucasian women reported the strongest cohesion to the values of the dominant Anglo culture *and* received the greatest amount of professional treatment for their eating disorders, and then also reported the most strained mother-daughter relationships. Furthermore, previous researchers have classified Latinas as being "in the middle" of African American and Caucasian women with respect to their adoption of Anglo values about femininity and physical appearance (Bay-Cheng et al., 2002), and the number of strained mother-daughter relationships among the Latinas in this study were also at the mid-point of the continuum. It seems plausible that the perception of these relationships may be a self-fulfilling prophecy, such that if the culture looks for and expects unhealthy mother-daughter relationships, then the families unknowingly internalize and comply with this expectation (or, at least, the women characterize them

this way). Thus, since Caucasian women seemingly internalized the most messages, particularly from mental health professionals, then the true nature of these mother-daughter relationships is brought into question. Furthermore, if perceptions can be shaped by negative cultural expectations, it seems likely that they could also be influenced by positive, strength-based messages. As the eating disorder field slowly shifts from identifying mothers as the cause of these illnesses to a multifactorial understanding of eating disorders, it will be interesting to note if and how families' reports of strained versus healthy mother-daughter relationships change.

While feminist and womanist (Walker, 1983) theories are useful in helping to interpret the positive nature of the African American mother-daughter relationships, they do not provide a complete framework. First, these models do not necessarily account for why the women's relationships with their brothers were important sources of support. There were virtually no differences in the number of African American women with all sisters, all brothers, or both brothers and sisters who reported healthy sibling relationships. Some of these brother relationships were, in fact, of a protective "big brother" nature such that the women felt cared for by their brothers, and some of the women were caregivers to their brothers or simply related to them as siblings with no power differentials. This theoretical framework is unable to account for how these various types of brother-sister relationships were supportive in spite of seemingly inherent power and control differentials.

Likewise, feminist and womanist (Walker, 1983) theories also are not helpful in understanding the role of fathers in these women's illnesses. Feminists assert that a patriarchal culture does not hold absent and abusive fathers accountable for the negative

influence their behaviors may have on their daughters' development, and that more cultural attention needs to be given to this dynamic (Rabinor, 1994). However, the majority of African American women in this study did not consider the strained father-daughter relationship to be one of the most influential components of their experiences with bulimia. This finding reveals a sharp contrast in feminist theory versus feminist research – feminist *theory* argues that these women have accepted the dominant discourse that fathers' abuse or absence is not important or influential in their lives; feminist *research* reveres women's own accounts of their lives, and so if these women said the father-daughter relationships were not greatly associated with their experiences of bulimia, then that is their truth. Consequently, this inconsistency as to whether or not these relationships actually have negative effects on women propagates questions about the true role of fathers in African American women's (and all women's) experiences with bulimia. Did these women unknowingly downplay the negative effects of their fathers' absence in their narratives because of patriarchal subjugation? Or, were there other cultural/familial elements that protected these women from the supposed negative effects of these relationships? Because the focus of this study was not directly aimed at the gendered nature of women's relationships with significant men in their lives, data from this study do not provide sufficient insight into how brothers and fathers intricately influenced participants' lives, particularly with respect to bulimia. However, the emergence of this finding certainly warrants more specific research into how fathers, brothers, and other male kin affect women's experiences with bulimia, both positively and negatively, and how these effects may differ in various racial/cultural contexts. Clearly, feminists' designation of patriarchy as paramount in the types of oppression and

sociocultural challenges that minority women may experience does not provide a holistic framework for interpreting the data of this study.

Turning to family systems theory, no useful insight as to why African American families were perceived by the women as healthier and less strained than the Latino and Caucasian families was offered by the application of this theory. There were more supportive subsystems, healthier boundaries, and more open communication in the African American families, but this theory falls short in accounting for the racial/cultural disparities. Thus, a supplement to family systems theory that may better account for the unique familial experiences of the African American women draws on the principles of the African worldview (Randolph & Koblinsky, 2003), which recognizes the racial/cultural “strands of ancient African history, culture, and philosophy” that influence African American families today (p. 31). Moving beyond the universal family concepts of boundaries, homeostasis, and subsystems, elements of the African worldview include, but are not limited to, spirituality, communalism, harmony, expressive communication, affect sensitivity, and positivity. All of these components value the respectful and supportive nature of family relationships. Application of this worldview to a feminist-family systems framework helps to explain how these families valued more *positive* mother-daughter relationships, and why the home environments were more *communicative* and *harmonious* as compared to the Latino and Caucasian families. To date, no known studies have used this worldview as a framework for studying eating disorders in the African American community, however this model clearly enhances the current understanding of how and why diverse family systems function as they do.

In sum, the feminist-family systems framework is useful in understanding how mother-daughter and sister relationships may have uniquely provided a supportive environment for the African American women affected by bulimia. However, principles from womanist theory (Walker, 1983) and the African worldview (Randolph & Koblinsky, 2003) need to be incorporated into this framework to provide a more racially and culturally sensitive framework that accounts for the distinct qualities of these families' experiences when compared to their Latina and Caucasian counterparts.

#### *Family Support Following Revelation of Bulimia*

The fourth significant finding with respect to understanding minority women's experiences with bulimia was the degree to which the African American women and Latinas felt more supported by their families than the Caucasian women after disclosing bulimia. Approximately three-quarters of the minority women felt comforted and encouraged after sharing their secret with family members (most often parents); less than half of the Caucasian women felt this way about their families' responses. This is a particularly noteworthy finding when situated amidst constraining cultural and familial contexts. Culturally, the intense stigmas associated with eating disorders and professional treatment permeated the African American and Latino cultures, leaving them to feel like "the only one" with this shameful illness; yet, they still felt accepted by their families. In contrast, the Caucasian women felt "typical" and "average" due to their culture's passive acceptance of eating disorders, but their families were perceived as the least supportive once they learned of the illness. These are contrasting findings such that cultural familiarity did not necessarily translate into familial support for the Caucasian women, whereas the lack of cultural familiarity co-existed with familial support among the



minority families. This poses questions about minority families' abilities to convey support of their daughters in the face of strong cultural shame and little familial understanding of the disease. Furthermore, this finding brings into question the validity of existing research (with predominantly Caucasian samples) that suggests families affected by bulimia are mutually unsupportive and unable to effectively resolve problems (Kog & Vandereycken, 1989; Striegel-Moore et al., 1986).

Interestingly, although African American and Latina women felt their families were supportive, a full three-quarters described their families as having little to no direct communication about the eating disorder once it was disclosed. This juxtaposition of family support and poor family communication challenges the broad definition of 'communication' in family systems theory and the circumplex model, in which heavy emphasis is placed on verbal, direct communication between members. In fact, according to the circumplex model, a widely used model in eating disorder research, healthy communication is defined by listening and speaking skills, self-disclosure, clarity of conversation, and respect for others participating in the conversation – all of these factors are related to the verbal communication between members. However, as the finding from the present study suggests, verbal communication specific to bulimia was limited and yet the minority women still described their families as cohesive and flexible after learning of the eating disorder. In fact, when asked how they knew that their families supported them even though they did not talk about bulimia, many of the minority women said that their parents read books about eating disorders, began cooking healthier foods and exercising with their daughters, and sought individual therapy for them. The women also considered the fact that many of their parents probably had no idea how to *talk* about this

stigmatized illness because of the cultural silence surrounding this topic, and so they compensated by *doing* things to show their support. As a result, the parents' actions, and not necessarily their words, conveyed a judgment-free "forgiveness" that was comforting and supportive for many of the women in the present study. Thus, it seems plausible that oral communication may not always be the primary way in which families, particularly racial minority families, convey their unconditional love and willingness to adapt to members' needs. Perhaps this notion of verbal communication is more representative of how healthy Caucasian families manage the family system, and does not necessarily translate as well when applied to minority families.

A more culturally sensitive expansion of family systems theory could include both verbal and non-verbal communication, in which unspoken communication may at times be considered more important in understanding family functioning. This emphasis on non-verbal communication would demonstrate a valuing of the multiple ways in which systems can enhance their subsystems and boundaries, and ultimately maintain a healthy homeostasis. Furthermore, this pairing of verbal and behavioral communication embodies aspects of the African and Latino worldviews. According to the aforementioned African worldview (Randolph & Koblinsky, 2003), "synthesis of the verbal and nonverbal" are important dimensions of how African American parents and their children convey cognitions and emotions to each other (p. 31). Similarly, the Latino worldview values communication patterns that are indirect and nonverbal, but still sensitive to others' feelings (Delcampo, 2008). By expanding family systems theory with these culturally sensitive worldviews, the qualities of feminist research become integrated in that women and their families would be studied using a contextual approach with

multiple research designs and methodologies (Striegel-Moore, 1994). Furthermore, by incorporating racial/cultural sensitivities to minority families' functioning, and using both quantitative and qualitative designs to test various dimensions of family functioning, the minority family is more accurately represented and understood.

### *Theoretical Conclusion*

As this discussion of noteworthy contributions demonstrates, the existing feminist-family systems theoretical framework is useful in understanding and interpreting many of these findings, yet an enhanced model that provides versatility in addressing families' unique cultural experiences is necessary for a more holistic analysis of the data. At a micro level, family dynamics are generally understood in the context of the system's boundaries, subsystems, and ability to maintain a healthy level homeostasis. As these findings demonstrate, family systems theory is useful in highlighting the integral role of the women's families in their experiences with bulimia, such that their relationships with other members contextualized the women's individual experiences with the illness. Furthermore, findings also demonstrated how minority families were particularly skilled at remaining flexible and interconnected once the illness was disclosed – a finding that had yet to be uncovered in previous research (Klein & White, 1996; Krauss & Jacobs, 1990; Winton, 1995). Additionally, a macro level approach using general feminist, womanist (Walker, 1983), and Latina feminist (Comas-Diaz, 1988) theories provides a cultural context for understanding how women from diverse backgrounds develop the same illness amidst very different oppressive forces based on one's racial/cultural context. While all of the women were faced with sexism, the African American women and Latinas were especially challenged with pressures of racism, acculturation, and

cultural clashes in expectations and values. This combination of micro- and macro-level theories is absolutely necessary in understanding minority women's experiences with bulimia. Simply using family systems theory to clarify these findings provides no racial or cultural insight into how and why the African American, Latina, and Caucasian women had very different experiences with bulimia. Similarly, while feminist theory is much more useful than family systems theory in its abilities to consider the cultural contexts of women living in a patriarchal society, it does not always account for differences by race/culture, and thus it misses the uniqueness with which some families of color remain resilient in the face of distinct cultural barriers and stressors.

The use of general feminist theory to understand eating disorders is certainly a huge step in the right direction, however aspects of more specific feminist theories, such as womanist (Walker, 1983) and Latina feminist (Comas-Diaz, 1988) theories, provide a more useful and holistic framework from which these illnesses are understood. To date, the pairing of womanist theory with the topic of eating disorders is rare, and often only in small publications that are theoretical in nature and not applied to empirical research. The use of Latina feminist theory in understanding eating disorders is simply non-existent. Furthermore, inclusion of race-specific models, such as the African (Randolph & Koblinsky, 2003) and Latino (Delcampo, 2008) worldviews, along with Helms' (1995) model of Black racial identity, addresses the present study's need for more clarity as to how and why African American, Latina, and Caucasian women were similar and different in their cultural and familial experiences with bulimia. As the present study demonstrates, relying on general theories that are not racially sensitive to interpret and understand research findings cannot account for all of the experiences of minority women

and families affected by eating disorders. Thus, if the field of eating disorders truly wants to answer new research questions like “Which environmental factors make the development of eating disorders more (e.g., acculturative stress) or less (e.g., higher weight ideal) likely in ethnic minority women?” (Franko, 2007), then the inclusion of race- and culture-specific theories is absolutely necessary. Through ongoing inclusion of these theories, individuals and families of all backgrounds are well represented in the research, and discussion of racial minorities affected by eating disorders is launched into the dominant discourse on mental health issues.

### Strengths

A paramount strength of the present study is the qualitative design, in which women from diverse backgrounds were afforded the opportunity to collaborate on a research project and contribute to the advancement of knowledge about a topic that traditionally has been ignored in the research. While many studies on eating disorders use scientific quantitative measures designed by researchers who presume to know the key processes associated with these illnesses, the current study allowed for the emergence of any processes deemed important by the women, and only used preexisting theories to shape the study, not control it.

A second strength of the present study is the cultural diversity of participants, in which two-thirds of the women were racial minorities. Often, studies about eating disorders include predominantly or all Caucasian samples, yet the results are then generalized to a larger sample of women from diverse backgrounds. By including equal numbers of African American, Latina, and Caucasian women, findings are more generalizable across these racial groups. Additionally, while very little was known about

the cultural variations in women's experiences with bulimia, the current study laid the foundation for further investigation of how a person's racial/cultural background affects their experiences with eating disorders.

Building on the racial diversity of the participants, the present study is further strengthened by the unique exploration of both racial *and* cultural processes that influenced women's experiences with bulimia; neither was used as a proxy for the other. Throughout the interview, women were given the opportunity to talk about their experiences with bulimia in the context of their cultural and familial environments, and as a result the women spoke about both racial and cultural issues. References to skin color, hair type, and body shape shed light on their racial experiences as a woman with bulimia. Stories of how Caucasian women felt "normal" having bulimia whereas minority women felt like "the only one," spoke to their cultural experiences with the illness. Thus, while race was used as a recruitment criterion, it certainly did not stand in the way of women using their cultural "tool kits" (Swidler, 1986) to fully explore their experiences with an eating disorder.

Fourth, the current study provides strong evidence to debunk the ongoing myth that families are responsible for the development of their daughter's eating disorders, and shows how families are one component of this larger process. For so long, researchers and practitioners perpetuated the belief that parents were to blame for their daughters' illness, and even in spite of emerging research on genetics and sociocultural issues that suggest otherwise, this myth continues to permeate the eating disorder community. In the present study, only 6% of the women identified their family as the sole issue they considered in understanding why their eating disorder developed. Additionally, many of

the minority women cited positive, healthy relationships with their families, and some of these relationships actually helped the women recover from their illness. Thus, findings from the current study remind the eating disorder community that most women do not perceive their families as responsible for their illness, and they often look to their families for support.

Fifth, in spite of the qualitative and subjective nature of the present study, several steps were taken to ensure the trustworthiness and authenticity of this study's analyses. Peer reviews allowed for my colleagues and research assistants to share their thoughts, suggestions, and questions about the study, which in turn encouraged me to consider ideas that I may not have generated on my own. I also triangulated the data, in that I used multiple theories and multiple data sources (e.g., interviews, field notes) to guide the study. Finally, member checks allowed for all of the participants to read a draft of the results and provide feedback about how they were represented and how their story was used to advance the understanding of women's experiences with bulimia.

Finally, another strength of the current study, of which I am most proud, is the degree to which participating in this research was a positive and insightful experience for the women. Many of the women shared how the interview allowed them to finally break free from the silence of their illness while also gaining insight into their own life and experiences. They also felt a certain level of pride in knowing that they were a part of effecting social change (Striegel-Moore, 1994), such that their story would one day help another woman in a similar position and impart valuable knowledge to professionals working with this population. Furthermore, of most importance to me, they all felt respected and validated throughout the interview. This feedback put to rest my concerns

that an “outsider,” by both race and experience, could not earn the trust of participants and/or conduct sound research. Rather, I believe this *etic* perspective strengthened my yearning to ask more questions and ultimately just listen to these women’s interpretations of their lives.

### Implications

The purpose of the current study was to understand how women from diverse backgrounds describe their experiences with bulimia. However, my long-term goal is to use these findings to improve existing therapy models and programs so as to better meet the cultural needs of diverse families affected by eating disorders. Toward that end, I will consider the implications of this research for future research and practice. First introduced by Cross, Bazron, Dennis, and Isaacs (1989), there are five important elements of cultural competency that all research studies, policies, and clinical practices should strive to achieve: (1) embrace and value diversity; (2) conduct cultural self-assessments; (3) remain cognizant of dynamics between and within cultures; (4) institutionalize cultural knowledge; and (5) adapt services to meet the needs of diverse cultures. As findings from this study support, implications for research, policy, and practice can be guided by these five principles.

### *Research*

Both general and specific areas of future research emerged from the present study. In general, more research is needed on how eating disorders affect people of all backgrounds. According to the U.S. Census Bureau (2001), nearly half of all Americans will be racial minorities by the year 2025. However, as these numbers quickly increase with time, eating disorder research that includes minorities is not keeping pace. It is no



longer acceptable to use predominantly Caucasian samples to study a phenomenon that is not color-blind. Thus, it is imperative that future studies continue to address racial/cultural similarities and variations in people's experiences with eating disorders at all levels, from sociocultural to familial to individual.

In addition to broadening the *topics* related to families affected by eating disorders, it is also imperative that this research is expanded to include other *people* with eating disorders. While the present study only included African American women and Latinas in the minority sample, future studies should include Asian American and Native American participants. Furthermore, eating disorder research must also consider the experiences of other cultural "minorities" who are often neglected from eating disorder studies, including men, middle-aged and elderly people, and lesbian, gay, bisexual, and transgendered people affected by eating disorders. Once research on eating disorders consistently *values diversity*, the potential for *cultural knowledge to be institutionalized* improves exponentially.

Furthermore, it is also important to study other types of eating disorders using a similar racial/cultural framework and qualitative methodology. For example, anorexia nervosa is considered virtually non-existent in minority populations, despite ongoing reports suggesting otherwise. Thus, while recruitment of minority participants may be slow and tedious, it is necessary that future research consider how minority women's experiences of anorexia, binge eating, and other eating disorders are shaped in part by their racial/cultural backgrounds. Further replications of the current study should also include interviewers of diverse backgrounds, so as to minimize the possible effects of mistrust among the races with respect to recruitment.

Specific issues that emerged from the present study also warrant more research due to inadequate existing research on the topic or because the findings contradict previous research. First, future studies should continue to investigate the positive nature of African American and Latino families affected by bulimia. More insight into how these families remained positive in the face of a culturally stigmatized illness is needed, as well as how they can serve as positive role models for other families stricken by bulimia.

Second, additional studies should be conducted to better understand how conflict in families affected by bulimia is experienced. Previous research has consistently found that high levels of interpersonal conflict are common in these families (Ackard & Neumark-Sztainer, 2001; Cachelin et al., 2003; Crowther et al., 2002), but findings from the current study revealed that silent tension was three times more prevalent than overt conflict. Clearly, more research is needed to explore how people from various racial groups affected by eating disorders define “conflict.” Certainly, silent tension is an uncomfortable state for members and may even be confused with overt conflict, and so clearly defining overt versus silent conflict may shed light on how these families manage discord between members.

A third emergent finding that calls for additional research was the disproportionate dispersion of women across birth orders. Most interestingly, over half of the women were the youngest in birth order, and yet the majority of them still felt pressure to be overly mature and responsible rather than fulfill the traditional role as the family’s “baby.” To date, few studies have explored the nature of birth order with respect to eating disorders, and the limited findings have produced inconclusive evidence as to if

and how these relationships influence women's experiences with bulimia. Some research (e.g., Eagles, Johnston, & Millar, 2005) has found increased numbers of youngest siblings in their sample, whereas other studies (e.g., Fox & James, 1976) found more oldest siblings. Still other research has found no pattern in birth order among women with bulimia (Britto, Meyers, Smith, & Palmer, 1997; Gowers, Kadambari, & Crisp, 1985). However, while these studies are original in their attempts to investigate a new aspect of families affected by eating disorders, none of them looked beyond the women's actual birth order to explore how the women's roles in their families may influence or be influenced by this sibling position. Future feminist research is needed to explore how age-inappropriate roles in the family, particularly in tandem with one's birth order, may deny women the power and control in their own families, similar to their experiences in the larger cultural context.

Fourth, the specific theme of managing difficult emotions was common to all three racial groups, but it emerged much more frequently for the Caucasian women than it did the African American women and Latinas. As a therapist myself, I was able to see the difficult emotions experienced by many of the minority women with respect to their eating disorders, and yet that was not the framework with which they talked about their disorder. Since the majority of minority women did not receive professional treatment for their eating disorders, and the majority of Caucasian women did, it begs the question of whether or not this phenomenon is a product of professional treatment, in which women were encouraged to explore their feelings surrounding the eating disorder and related issues. Thus, it is possible that the emotional experiences of this illness were not vastly different across racial groups, but the lexicons with which the minority women used to

describe their experiences were different. Additional qualitative research may be useful in further exploring this issue of how women from diverse backgrounds talk about their experiences with bulimia and how professional treatment can adjust women's understanding of their own illness; this information would be very helpful in developing therapy models that are adapted to the interpretations and experiences of people from different backgrounds.

Fifth, over half of the women spoke to the ongoing conflict between their parents. While this family dynamic supports previous research on families with eating disorders, which suggest that high levels of parental/marital discord are normative experiences for these women (Hodes, Timimi, & Robinson, 1998), no known research has investigated how this dynamic may differ by race/culture. The present study contributes a new element to this body of literature due to the stark differences in who reported more marital conflict – two-thirds of the African American and Caucasian women spoke of intense conflict between their parents, whereas only one-third of Latinas addressed this issue (in spite of the fact that the number of together versus separated parents at the time of their eating disorder was the same for both Latina and Caucasian women). Using a feminist-family systems framework, it is possible that the stress of immigration and acculturation actually created more closeness and camaraderie among Latino couples because they had to rely on each other for physical, financial, and emotional support during this time of chaos. In the families' efforts to remain adaptable and regain homeostasis, the couple increased their cohesion and kept conflict to a minimal level. Further research is needed to test this hypothesis and to understand how parents' relationships influence their children's experiences with eating disorders, particularly in

the context of sociocultural stressors that minority and/or immigrant families are more likely than Caucasian families to experience.

Finally, more research is needed to better understand how family systems and feminist theories can be enhanced to account for the diversity in experiences of racial minority families. Future studies should incorporate principles of womanist (Walker, 1983) and Latina feminist (Comas-Diaz, 1988) theories, as well as the African (Randolph & Koblinsky, 2003) and Latino (Delcampo, 2008) worldviews and black racial identity (Helms, 1995) development. Race- and culture-specific models such as these provide much-needed insight into how these illnesses operate, and must become a central part of rigorous eating disorder research.

### *Policy*

Findings from the current study revealed that minority women often avoided seeking treatment for their eating disorder due to the lack of culturally sensitive programs and practitioners. In response to this need, passage of Federal legislation, such as Mental Health Parity (SB 558, HR 1424) and the F.R.E.E.D. Act (Federal Response to Eliminating Eating Disorders; HR TBA), is necessary to ensure that treatment centers are available to all families and that nationally funded centers of excellence are developed with the goal of conducting rigorous, culturally competent research that *embraces and values diversity* and studies *all* populations affected by these illnesses.

Additionally, many of the women noted that their schools provided scant and/or inadequate education about eating disorders. Since it is well known that most eating disorders develop during the early- to middle-adolescent years, it is imperative for schools to develop policies with respect to providing effective prevention and

intervention programs that help adolescents of all backgrounds understand the dangers of these illnesses. Furthermore, educating teachers and other school personnel (e.g., nurses, principals) about the warning signs of eating disorders and the risk factors that may make a person more susceptible to developing one, particularly those processes specific to racial/cultural minority groups, is necessary for schools to systemically address this issue and *institutionalize cultural knowledge* about these rampant and deadly disorders.

### *Practice*

As the President's New Freedom Commission on Mental Health (2003) noted, mental health services have yet to adjust to the growing diversity of clients' needs. As a result, millions of people, most notably minorities, are not receiving adequate mental health care, which was echoed in many of the participants' inability to find culturally competent treatment for their eating disorders. Since the purpose of the present study was to learn from women about their experiences with bulimia in a way that could eventually inform the development of culturally sensitive treatment models for eating disorders, many practice implications emerged from the findings.

First, it is imperative that *services be modified to meet the needs of culturally diverse populations*. Intervention and treatment programs must seek out culturally appropriate ways in which people and families of color are invited to access services, particularly since the stigma of having an eating disorder is so intense in the African American and Latin communities. For example, marketing efforts specifically targeted to minorities affected by eating disorders may reduce the stigma that this illness only affects white women. Participants from the present study suggested broadcasting commercials about eating disorders that not only depict African American women and Latinas, but

also briefly describe the warning signs of an eating disorder and emphasize that minority women are just as susceptible to developing these illnesses as are Caucasian women. They believed that public service announcements like these would send the message that minorities are not alone in their struggles, and that these are treatable illnesses.

In addition to breaking down stigmas for the women, it is also important to educate minority parents about eating disorders so that they feel empowered to help their daughters in spite of cultural aversions to mental health issues. Again, based on participants' feedback, targeting mothers via churches and schools may be most effective in disseminating information about eating disorders, which could include the warning signs, the different types of disorders, and what to do if a family member suspects that somebody has one. Furthermore, the professionals providing this information should be diverse in racial and cultural backgrounds, so that cultural trust may be formed and language barriers (e.g., Spanish-speaking family) may be overcome.

Second, once women and families of color feel comfortable seeking treatment, it is important for practitioners to *remain cognizant of cultural dynamics* and recognize that these women may develop eating disorders for very different reasons than Caucasian women. As the current findings suggest, African American women related their experiences of bulimia to feelings of being caught in a bicultural context and fearing that their families and culture would dismiss the illness. In contrast, the Latinas often equated their illnesses with acculturative stress associated with immigration and cultural gaps across generations. These experiences tend to be different from the “normative” experiences of Caucasian women, who may associate their eating disorders with cultural pressures to be thin and overwhelming emotions of stress or loneliness. Thus, when

working with women from diverse backgrounds, it is imperative for treatment providers to incorporate the cultural experiences of each client into their assessment of the disorder.

Third, it is vital that all practitioners regularly *conduct cultural self-assessments*, in which their own competencies to work with people of different backgrounds are evaluated. Examples of assessment questions include “Do you know the prevailing beliefs, customs, norms, and values of the groups of color in your service area?” and “Do you know the social service needs within groups of color that go unaddressed by the formal social service system?” (Mason, 1995). Based on practitioners’ answers on these assessments, they may be classified into one of six levels of cultural competence, which include: (1) cultural destructiveness, (2) cultural incapacity, (3) cultural blindness, (4) cultural pre-competence, (5) cultural competence, and (6) cultural proficiency. Providers and agencies who achieve levels five and six on this continuum demonstrate an unconditional acceptance for people of all cultures, and use culture to guide the fundamental operations of their work (Cross et al., 1989). Culturally competent and proficient endeavors in the field of eating disorder treatment include writing manuals and conducting workshops for therapists that specifically address the racial and cultural nuances in working with minorities affected by eating disorders; assessing predominantly Anglo-centric treatment models that have yet to be validated using minority populations; and incorporating experiences of oppression, racism, and bicultural experiences into dialogues about the women’s insight into their illnesses (Palmer, 2007).

### Conclusion

The current study explored how African American, Latina, and Caucasian women described their experiences with bulimia through the lens of their racial, cultural, and



familial contexts. Findings uniquely contribute to the literature on how this experience is similar and different for women from diverse backgrounds. The present study is the first known project to interview women of color about their experiences of bulimia in the contexts of their families and to ask about their experiences of being a minority woman with a culturally stigmatized illness. Furthermore, this study revealed how women from diverse backgrounds experience bulimia differently, both in their families as well as in the larger culture. Findings revealed that while all of the participants struggled with social pressures to be thin, strained family relationships, and comorbid disorders, women from each racial group spoke to different reasons that ultimately shaped their understanding of the illness (e.g., bicultural context, acculturative stress). Furthermore, findings also suggest that current services available to people affected by eating disorders are not culturally sensitive, which deterred many of the women in this sample from seeking treatment. These results pave the way for important suggestions as to how intervention and treatment programs can provide more culturally competent services to individuals and families affected by eating disorders.

More research, both quantitative *and* qualitative, is needed to explore how people of all backgrounds experience and describe their eating disorders. As the women in the current study attested to, when given the opportunity to fully participate in a research project that solicits and values diverse voices, the experience is both empowering and enlightening for all involved. For many of them, the interview afforded them the opportunity to think about their story in a new way or make connections that they had yet to discover, like Mariana (L) who shared, “You definitely asked questions that made me think about things in a different way,” and Samantha (A) who told me, “It helps me

understand myself and it helps me understand where it's rooted...it just makes so much sense now." The opportunity to share their story, make sense of it, and have their experiences validated as meaningful and important seemed to be a turning point for these women in better understanding their own lives and learning that they are not alone or insignificant. I am forever grateful for the 33 women who were brave enough to share their personal stories; I hope that I have appropriately recounted their narratives in a way that conveys their universal experiences, their individual and cultural variances, and most importantly, their strength to persevere.

## APPENDICES

## Appendix A: Recruitment Letter to Mental Health Professionals

Dear XXX,

My name is Ashley Southard and I am a doctoral candidate in the Department of Family Science at the University of Maryland, College Park. I am also a licensed marriage and family therapist with a private practice in Columbia, MD treating people with eating disorders, and I have recently worked with the Eating Disorders Coalition for Research, Policy, and Action, an eating disorder advocacy group in Washington, DC.

I am writing to ask for your assistance in recruiting women for my dissertation research, which explores women's experiences of bulimia in the context of their family environments and racial/ethnic cultures. I hope to use the findings from this study to develop more culturally sensitive family therapy models for minority individuals and families seeking treatment for bulimia. All data will be collected from in-person interviews with women who have struggled with bulimia.

To be eligible to participate in this study, women must meet the following criteria:

- Be between the ages of 18-25 years
- Self-identify as Latina, African American, or Caucasian
- Have lived with their parent(s) during a portion of the time that they struggled with bulimia

Interviews are approximately 90-minutes in length and I will drive to meet the participant in a location that is convenient for them. All participants will be given \$25 for their time and identifying information will be kept strictly confidential and anonymous. More information is available on my website at [www.ashleysouthard.com](http://www.ashleysouthard.com) under the "Research" link.

If you have any current or former clients who you think might be eligible to participate, I would greatly appreciate your assistance in sharing this information with them. I have included several fliers that you can give to clients, post in your waiting room, or pass out to other therapists who may also have eligible clients. Any women interested in doing an interview may contact me directly on my cell phone at (443) 538-5787 or via email at [jasouthard@gmail.com](mailto:jasouthard@gmail.com). I also invite you to contact me via phone or email should you have any additional questions about this study.

Thank you in advance for your time and thoughtful consideration of this request. With your help, this research will hopefully shed new light on how these deadly illnesses affect ethnic minority families, as well as how we as mental health providers and nutritionists can work to help these families in need.

Warmly,

Ashley Southard  
Department of Family Studies  
University of Maryland, College Park

### **Research Opportunity for Women Affected by Bulimia**

If you are an **African American, Latina, or Caucasian woman** between the ages of 18 to 25 who has been affected by the eating disorder **bulimia**, you may be eligible to participate in a research study. This study is being conducted by Ashley Southard, a doctoral candidate in the Department of Family Science at the University of Maryland, College Park. The purpose of Ashley's dissertation is to explore how a woman's family and race/ethnic cultures may influence her experiences of bulimia. Findings from this study will be used to develop more culturally appropriate family therapy treatments for eating disorders. If you would like more information about this study, please visit Ashley's website at [www.ashleysouthard.com](http://www.ashleysouthard.com) and click on the "Research" link.

If you have further questions or are interested in doing a **90-minute in-person interview** with Ashley, please contact her via email at [jasouthard@gmail.com](mailto:jasouthard@gmail.com) or by phone (443) 538-5787. Participants will be **given \$25** for their time. Identifying information will be kept strictly confidential.

#### **Eligibility Criteria**

- Woman between the ages of 18-25 years
- Self-identify as African American, Latina, or Caucasian
- Affected by bulimia at some point in life (you do not need to be recovered or have received a formal diagnosis of bulimia to participate)
- Lived with your parent(s) during a portion of the time that you had bulimia

#### **Contact Information**

Ashley Southard  
(443) 538-5787  
[jasouthard@gmail.com](mailto:jasouthard@gmail.com)  
[www.ashleysouthard.com](http://www.ashleysouthard.com)

## Appendix C: Newspaper Advertisements

**Newspaper:** Eclipse (African American newspaper at University of Maryland)

**Date of printed advertisement:** September 2007

**Text of advertisement:**

Women Needed for Bulimia Research

Earn \$25 for 2-hour Interview

African American and Latina women, ages 18-25, needed for dissertation research on bulimia. To qualify, women must have had bulimia (no diagnosis needed) and they must have lived with a parent(s) during some portion of the time they were affected by bulimia. Women do not need to be recovered from bulimia at this time in order to participate. Interviews are approximately 90 minutes and are conducted in Marie Mount Hall, room 1309. Participants are given \$25 for completing the interview. Interviews are audio taped and all information is kept strictly confidential. For more information about the study, please visit [www.ashleysouthard.com](http://www.ashleysouthard.com). To participate in the study, please contact Ashley Southard at 443-538-5787 or [jasouthard@gmail.com](mailto:jasouthard@gmail.com).

**Newspaper:** Washington City Paper

**Date of printed advertisement:** September 21, 2007

**Text of advertisement:**

Bulimia Research, \$25

African American, Latina, and Caucasian women, ages 18-30, who have struggled with bulimia and lived with parent(s) at time. Earn \$25 for interview. Contact Ashley Southard at (443)538-5787 or [jasouthard@gmail.com](mailto:jasouthard@gmail.com) for more information.

**Newspaper:** Washington Hispanic

**Date of printed advertisement:** September 28, 2007

**Text of advertisement:**

Bulimia Research

Hispanic women, ages 18-30, who have had bulimia and lived with a parent during this time. Earn \$25 for interview. Contact Ashley at (443) 538-5787 or [jasouthard@gmail.com](mailto:jasouthard@gmail.com)

### **Bulimia Research**

If you are an African American or Latina woman between the ages of 18 to 30 who has struggled with the eating disorder bulimia, you may be eligible to participate in a research study. This study is being conducted by Ashley Southard, a doctoral candidate in the Department of Family Science at UMCP. The study explores how a woman's family and race/ethnic cultures may influence her experiences of bulimia. Findings will be used to develop more culturally appropriate family therapy treatments for eating disorders.

To be eligible to participate you must meet all of the following criteria:

- Woman between the ages of 18-30 years
- Self-identify as African American or Latina
- Affected by bulimia at some point in life (you do not need to be recovered or have received a formal diagnosis of bulimia to participate)
- Lived with your parent(s) during a portion of the time that you had bulimia

If you have further questions or are interested in doing a 90-minute in-person interview on campus with Ashley, please contact her via email at [jasouthard@gmail.com](mailto:jasouthard@gmail.com) or by phone (443) 538-5787. Participants will be given \$25 for completing the interview AND \$25 for each referral they make who also completes an interview.

All identifying information will be kept strictly confidential.

**Bulimia research: Minority women, ages 18-30, earn \$25 (MD/DC/VA)**

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Reply to: [jasouthard@gmail.com](mailto:jasouthard@gmail.com)

African American and Latina women, ages 18 to 30, who have struggled with the eating disorder bulimia and lived with a parent at the time - you may be eligible to participate in a research study. The study explores how a woman's family and race/ethnic cultures may influence her experiences of bulimia. Findings will be used to develop more culturally appropriate family therapy treatments for eating disorders.

To be eligible to participate you must meet all of the following criteria:

- African American or Latina woman between the ages of 18-30 years
- Affected by bulimia at some point in life (you do not need to be recovered or have received a formal diagnosis of bulimia to participate)
- Lived with your parent(s) during a portion of the time that you had bulimia

Participation involves completing a 2-hour in-person interview in the MD/DC/VA area – where ever is convenient for you. Earn \$25 upon completing the interview. To participate, please contact Ashley Southard at [jasouthard@gmail.com](mailto:jasouthard@gmail.com) or (443) 538-5787.

Location: MD/DC/VA

It's NOT ok to contact this poster with services or other commercial interests

Compensation: \$25 for completing interview



Appendix F: Interview Informed Consent Form

**Interview Informed Consent Form**

Understanding eating disorders: A qualitative exploration of the roles of race and family

Directions: Please read both sides of the consent form and sign your name on the back side of this form. Your signature indicates that you understand and agree to the information outlined in each paragraph.

|   |
|---|
| <p>You are over 18 years of age and agree to participate in a program of research being conducted by Dr. Leigh A. Leslie and Ashley L. Southard in the Department of Family Science at the University of Maryland, College Park.</p>  |
| <p>We are inviting you to participate in this research project because you are a woman between the ages of 18-30 who self-identifies as African American, Latina, or Caucasian and you have struggled with bulimia while living with your parent(s) and possibly other family members. The purpose of this research project is to explore participants' experiences of living with their families before and during the time they struggled with bulimia.</p>   |
| <p>The procedures involve an in-depth individual interview that will either be in-person or over the telephone and will last approximately 90 minutes. During the interview, you will be asked questions related to your experiences with bulimia with respect to your family and racial background. Examples of questions you will be asked include:</p> <ul style="list-style-type: none"><li>• What was going on in your life before your struggle with bulimia developed?</li><li>• What was your family like at the time when bulimia entered your life?</li><li>• How do you think bulimia has changed your family as a whole?</li></ul>  |
| <p>You give your permission to have your interview audio taped, whether the interview is in person or over the phone. Audiotapes will be kept in a locked file cabinet in the researcher's office at the University of Maryland, College Park. Only the study investigators and paid transcribers, who will sign a confidentiality form, will have access to the tapes. Once the study is completed, the audiotapes will be destroyed.</p>  |
| <p>All information collected in this study is confidential. You will be assigned a unique 5-digit code and a code name in place of your real name. You understand that the data you provide will be grouped with data provided by other participants for reporting and presentation and that when your data are specifically referred to, the code name will be used in place of your real name. In accordance with legal requirements and professional standards, we will disclose confidential information to the appropriate individuals and/or authorities if: (1) you or someone else is in grave danger, (2) you disclose physical, emotional, and/or sexual abuse of a child or disabled/elderly adult, or (3) if required by the law or the courts.</p> |
| <p>There may be some risks associated with participating in this research study. Interview</p>  |

|  |
|--|
| <p>questions may bring about emotionally disturbing memories or may make you feel uncomfortable or embarrassed. If you would like professional therapy after participating in this interview, please visit <a href="http://www.edreferral.com">www.edreferral.com</a> to locate a therapist in your area who specializes in treating eating disorders. Neither the researchers nor the University of Maryland will provide financial compensation for these services.</p>  |
| <p>The study is not designed to help you personally, but to help the investigators learn more about the experiences of women with bulimia. We hope that, in the future, other people might benefit from this study through improved understanding of how family and race may influence women’s struggles with bulimia.</p>   |
| <p>Your participation in this research is completely voluntary. You may choose to not participate at all, and if you decide to participate you may withdraw at any time without penalty. You are free to ask questions before or during the interview. You understand that you will receive \$25 for your involvement in this study, regardless of whether or not you choose to withdraw from the study.</p>   |
| <p>The University of Maryland does not provide any medical, hospitalization, or other insurance for participants in this research study, nor will the University of Maryland provide any medical treatment or compensation for any injury sustained as a result of participation in this research study, except as required by law.</p>  |
| <p>You are welcome to contact the study investigators at any time:<br/> Dr. Leigh Leslie, 1204 Marie Mount Hall, Department of Family Studies, University of Maryland, College Park, MD 20742, Phone: (301) 405-3672; Email: <a href="mailto:lleslie@umd.edu">lleslie@umd.edu</a><br/><br/> Ashley Southard, 1204 Marie Mount Hall, Department of Family Studies, University of Maryland, College Park, MD 20742, Phone: (301) 405-8940; Email: <a href="mailto:jasouthard@gmail.com">jasouthard@gmail.com</a></p> |
| <p>If you have questions about your rights as a research participant or wish to report a research-related injury, please contact: Institutional Review Board Office, University of Maryland, College Park, MD 20742; (email) <a href="mailto:irb@deans.umd.edu">irb@deans.umd.edu</a>; (telephone) 301-405-0678.</p>   |
| <p>This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.</p>   |

*I have read the above information and I understand and agree to the guidelines. My signature below affirms my informed and voluntary consent to participate in this research.*

\_\_\_\_\_  
**Signature of Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Participant (please print)**

## Appendix G: Interview Protocol

Date: \_\_\_\_\_  
Type of Interview: In-person/Phone: \_\_\_\_\_  
Location of Participant (U.S. State): \_\_\_\_\_  
Code #: \_\_\_\_\_  
Code Name: \_\_\_\_\_

### ***Ashley to the participant:***

- Explore experiences with family throughout the time struggling with bulimia
- Think back to the time before you struggled with bulimia
- How your family interacted when you struggled with bulimia
- Lens of your racial and ethnic background, and larger culture in which we live
- “Family” = whoever you define as family
- Confidentiality
- Family therapist
- Hopes of being able to develop more effective treatment programs.
- Any questions about purpose of study or results?
- Discomfort, we can skip

### **EXPERIENCES BEFORE BULIMIA**

***Ashley:*** Okay, so first I’d like you to take me back to the family you grew up in – before bulimia developed. Who was in it? And, remember, it’s family as you define it.

1. Family genogram
  - a. *Siblings – names, ages, birth order, level of education, careers, partners/children<sup>7</sup>*
  - b. *Parents – names, ages, relationship history, siblings, where they live, level of education, careers*
  - c. *Grandparents – names, ages, relationship history, siblings, where they live, careers*
  - d. *Others as identified by the interviewee*
2. Describe how you were back at this time. What was going on in your life?
  - a. *Personality*
  - b. *Interests/Activities*
  - c. *Friends*
3. Describe how your family was back then.
  - a. *Members present*
  - b. *Activities together*

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<sup>7</sup> Italics serve as a reminder for the interviewer to gather this information; this information will not be directly requested unless the interviewee does not provide it in her answer.

- c. *Relationships with each other*
- 4. Describe general patterns of interactions and communication in your family.
- 5. Describe your relationship with your parent(s).
  - a. Was this the type of relationship you wanted with them?
- 6. [If siblings] Describe your relationship(s) with your sibling(s).
  - a. Was this the type of relationship you wanted with your sibling(s)?
- 7. Were there other family members who were an integral part of your life at that time? Describe those relationships.
  - a. Was this the type of relationship you wanted with this person/people?
- 8. How would a neighbor have described your family?
- 9. What would they have not seen?

### **COMMUNITY AND FAMILIAL CONTEXTS**

- 10. At this time, what kind of community or neighborhood were you living in?
  - a. *Family's socioeconomic status*
  - b. *Racial make-up of community*
  - c. *Racial make-up of schools*
- 11. In that school and community, were there messages about how you should look?
  - a. *What messages did you get?*
  - b. *About being a {PARTICIPANT'S RACE} woman?*
- 12. Do you recall ever hearing anything about eating disorders?

**\*\*OFFER TO TAKE A BREAK HERE\*\***

### **EXPERIENCES AFTER BULIMIA**

*Ashley:* Okay, for the next few questions, I'd like you to think back to the time when you started struggling with bulimia.

- 13. Tell me the story of how bulimia became a part of your life?
  - a. *Age and year*
  - b. *What else was going on at the time*
  - c. *Pivotal moment of when it started*

14. How do you make sense of why your eating disorder developed?
15. What was your family like at the time when bulimia entered your life?
16. Did your relationship change with your parent(s)? If yes, how did it change?
  - a. Was this the type of relationship you wanted with your parent(s)?
  - b. Were there any significant changes or turning points in the interactions and communication with your parents?
17. Did your relationship change with your sibling(s)? If yes, how did it change?
  - a. Was this the type of relationship you wanted with your sibling(s)?
  - b. Were there any significant changes or turning points in the interactions and communication with your siblings?
18. Did your relationship change with other family members? If yes, how did it change?
  - a. Was this the type of relationship you wanted with this person?
  - b. Were there any significant changes or turning points in the interactions and communication with these people?
19. Would your neighbor say that your family looked any different at this time as compared to before bulimia became a part of the family? If yes, how so?
20. Did anyone in your family find out about bulimia? If yes, who, how did they find out, and when did this happen?
21. Did anyone in your friendship network and/or larger community know about your eating disorder? If so, how did they find out?
22. How did your eating disorder affect your interactions with these people?
23. In thinking about the development of your eating disorder, how relevant is/was being {PARTICIPANT'S RACE} in {DESCRIPTION OF COMMUNITY}?

### **COMMUNITY AND FAMILIAL RESOURCES**

24. Was there anyone in your family, friendship network, and/or larger community to whom you turned for help with your bulimia? If yes, who was this person? How did you reach out for help? When did you reach out for help?

25. Were there any community resources that you knew of to help people with eating disorders? Did you use these resources?
26. Have you ever sought treatment for bulimia? If yes, what type of treatment(s) and for how long?
  - a. Did your family participate in any portion of the treatment? If yes, please describe their role in your treatment.
  - b. Did the treatment explore how your racial background may have influenced your eating disorder? If yes, how so?
  - c. Did the treatment explore how our larger culture may have influenced your eating disorder? If yes, how so?

### **CURRENT**

*Ashley:* Now, I'd like you to think about your life as it is today.

27. Do you consider yourself "recovered" from bulimia? Why or why not?
28. How do you think bulimia has affected your family as a whole?
29. How do you think bulimia has affected your role in your family?
30. How has your eating disorder affected the way you think of yourself as a {PARTICIPANT'S RACE} woman?

*Ashley:* Those are all of the interview questions that I have for you. What should I have asked you that I didn't think to ask?

Do you have any questions for me?

How was it like for you to talk about these issues? Was the interview what you expected it to be?

*Snowball:* Ask about friends/relatives who may want to participate.

If I have more questions for you that come up for me later, is it okay to contact you? And, if you think of something else that you forgot to say or if you just think of something else you'd like to tell me regarding your experiences as an adolescent, please call or email me – I'd love to hear from you.

There are three small things I wanted to check with you about before we end. First, I would like to use a pseudonym, or a fake name, when writing about your story. This

name will be used in place of your actual name so as to protect you and your family's identity. What name would you like me to use for you? \_\_\_\_\_

Ok, thanks. Second, I will be emailing my study findings – my interpretations and conclusions – to participants to get their feedback and reactions. Would you be willing to read those findings and get back to me with comments? YES NO

Ok, and if in the future I decide to collect some follow-up data through a survey or questionnaire, would you be willing to participate by filling out some forms like that?  
YES NO

As I mentioned before, I will keep your name and contact information in a separate, confidential file.

This is the end of the interview with {PARTICIPANT'S NAME}.

Appendix H: Codebook

| <b>Code Number</b> | <b>Code Label</b>                        | <b>Code Description</b>                                    |
|--------------------|--|--|
| 1                  | ECOLOGICAL & CHILDHOOD CONTEXTS          | Environments before ED developed                           |
| 11                 | Sociocultural                            |  |
| 111                | Messages About Appearance and Body Image |  |
| 1111               | Teasing                                  | Participants teased by peers for being overweight          |
| 112                | Gender-Based Expectations                | How to behave as a woman                                   |
| 113                | Learned About EDs                        | If and how women learned about EDs                         |
| 1131               | Media                                    | TV shows, commercials, and movies about EDs                |
| 1132               | School                                   | Health program/class about EDs                             |
| 1133               | Peers                                    | Students at school who had an ED or talked about them      |
| 1134               | Nothing                                  | No formal knowledge of EDs prior to developing one         |
| 12                 | Community                                |  |
| 121                | Racial/Cultural Diversity                |  |
| 122                | Socioeconomic Status                     |  |
| 123                | Schools                                  |  |
| 13                 | Familial                                 |  |
| 131                | Definition of 'Family'                   | Members included in definition                             |
| 132                | Education                                | Participants' levels of education                          |
| 133                | Parents' Careers                         |  |
| 134                | Country of Origin                        |  |
| 135                | Immigration                              | Age and year when participant or family immigrated to U.S. |
| 2                  | COMMON THEMES ACROSS RACE                | Emergent themes spoken of by all three racial groups       |
| 21                 | Sociocultural                            |  |
| 211                | Sports                                   | Participation in image-conscious sports                    |
| 212                | Comparison to Other Women                | Girl competition to look prettier and thinner              |
| 22                 | Family                                   |  |
| 221                | Family Communication                     | How much families talk about important issues              |
| 2211               | Lack of Communication                    | Evasion of deep issues                                     |
| 22111              | Avoid Conflict                           | Why families don't communicate                             |
| 2212               | Overt Conflict                           | Explosive and confrontational                              |



|       |                                     |  |
|-------|-------------------------------------|--|
|       |                                     | communication  |
| 222   | Strained Parent-Child Relationships |  |
| 2221  | Mother-Daughter                     | Participants' perceptions of relationships with their moms |
| 22211 | Little Cohesion                     | Lack of closeness between mothers and daughters            |
| 22212 | Open Communication                  | Daughters opened up to their moms about personal issues    |
| 22213 | Lack of Maternal Guidance           | Daughters wanted more parenting from mothers               |
| 2222  | Father-Daughter                     | Participants' perceptions of relationships with their dad  |
| 22221 | Emotional Distance                  | Father emotionally disengaged from daughter's life         |
| 22222 | Physically Absent                   | Father not present in daughter's life                      |
| 22223 | Abuse                               | Father emotionally, physically, and/or sexually abusive    |
| 2223  | Parents' Working                    | Excessive hours spent working away from family             |
| 2224  | Blame Parents for ED                | Identify parent(s) as cause of ED                          |
| 223   | Neighbors' Perceptions of Family    | How family wanted others to think of them                  |
| 224   | Expose ED to Family                 | Decision to tell family about ED                           |
| 2241  | Dropped Hints                       | Attempts to indirectly expose ED                           |
| 2242  | Did Not Tell Family                 |  |
| 22421 | Judgment/Criticism                  | Feared being judged or criticized by family                |
| 22422 | Burden                              | Feared being a burden to family                            |
| 2243  | Told Family                         | Directly communicated with family about ED                 |
| 22431 | Not supported                       | Felt unsupported by family after disclosing ED             |
| 22432 | Supported                           | Felt supported by family after disclosing ED               |
| 225   | Role in Family                      |  |
| 2251  | Parentified, Overly Responsible     | Expected to be mature, care for siblings                   |
| 2252  | Baby                                | Protected from 'real world'                                |
| 226   | Sibling Relationships               |  |
| 2261  | Birth Order                         | Oldest, middle, youngest, only                             |
| 2262  | Distant                             | Emotionally distant relationship with siblings             |
| 2263  | Close                               | Emotionally close relationship with siblings               |

|       |                        |   |
|-------|------------------------|---|
| 227   | Focus on Body Image    |   |
| 2271  | Critical Comments      | Negative messages about weight and appearance                 |
| 2272  | Enabling Parents       | Parents facilitate/encourage disordered eating and dieting    |
| 2273  | Parents' Own ED        | Number of parents who also struggle with food and weight      |
| 228   | Parents' Conflict      | Discord between parents                                       |
| 23    | Individual             |   |
| 231   | Comorbidity            | Other psychological disorders experienced with ED             |
| 2311  | Depression             |   |
| 2312  | Anxiety/OCD            |   |
| 232   | Management of Emotions | How cycle of ED helped to manage overwhelming emotions        |
| 2321  | Loneliness/sadness     |   |
| 2322  | Guilt                  |   |
| 233   | Control                | Feelings of not having control over body and/or life          |
| 2331  | Home                   | ED helped her feel in control of home environment             |
| 2332  | Abuse                  | Childhood physical and sexual abuse in which she lost control |
| 3     | RACE-SPECIFIC THEMES   | Emergent themes spoken of by one or two racial groups         |
| 31    | Sociocultural          |   |
| 311   | Bicultural Context     | Experiences of clash in cultures                              |
| 3111  | Acting white           | African American women teased for 'acting white'              |
| 3112  | Acculturation          | Immigrants negotiating conflicting cultural demands           |
| 312   | Cultural Stigmas       |   |
| 3121  | ED                     | Stigmas associated with EDs                                   |
| 31211 | White – Common         | White women experience ED as common in culture                |
| 31212 | Minority – Only One    | Minority women feel like only one with ED                     |
| 3122  | Treatment              | Stigmas associates with mental health treatment               |
| 31221 | Type                   | Type of treatment received, if any                            |
| 31222 | Crazy                  | Labeled 'crazy' for going outside of family for help with ED  |
| 31223 | Luxury                 | Treatment is an unnecessary luxury                            |
| 31224 | Professionals          | Few ED mental health professionals of color available         |

|     |                  |   |
|-----|------------------|---|
| 32  | Family           |   |
| 321 | Communication    | Level of effective family communication                     |
| 322 | Misunderstanding | Familial misunderstandings of ED because of cultural stigma |
| 33  | Individual       |   |
| 331 | Racial Identity  | Minority women wanting to 'be white'                        |

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