The present study investigated a culturally specific model of binge eating among African American women. As predicted, trauma, stress, and discriminatory stress were significantly related to binge eating symptomatology. Further, Strong Black Woman (SBW) ideology played an important moderating role, such that women strongly endorsing the SBW image reported greater binge eating symptomatology with increasing trauma exposure and distress, while binge eating among women low in SBW ideology did not vary significantly as a function of trauma exposure and distress. Structural path analyses revealed further differences between these two groups. Among women strongly endorsing the SBW image, stress exhibited strong positive relationships with emotional inhibition/regulation difficulties and self-silencing, and appeared to influence binge eating through its effects on these variables. In contrast, among women low in SBW ideology, stress was not as strongly related to emotional inhibition/regulation difficulties and self-silencing and instead had a direct effect on binge eating. In addition, key directional differences emerged such that discriminatory stress exhibited positive relationships with emotional inhibition/regulation difficulties and self-silencing among women low in SBW ideology and negative relationships among women high in SBW
ideology. Results of both sets of analyses indicated that emotional inhibition/regulation difficulties, self-silencing, and eating for psychological reasons each fully mediated the relationships between trauma, stress, discriminatory stress, and binge eating. These findings suggest that critical mechanisms by which traumatic, stressful, and discriminatory experiences influence African American women’s binge eating symptomatology are through increasing the likelihood or severity of emotion regulation difficulties, self-silencing behaviors, and the use of eating to fulfill psychological functions.
BINGE EATING AND THE “STRONG BLACK WOMAN”: AN EXPLANATORY MODEL OF BINGE EATING IN AFRICAN AMERICAN WOMEN

A dissertation submitted to Kent State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

by

Ellen F. Harrington

May, 2007
Dissertation written by
Ellen F. Harrington
B.A., Bowling Green State University, 2000
M.A., Kent State University, 2003
Ph.D., Kent State University, 2007

Approved by

____________________________________, Chair, Doctoral Dissertation Committee
Janis H. Crowther, Ph.D.
____________________________________, Members, Doctoral Dissertation Committee
Kristin D. Mickelson, Ph.D.
T. John Akamatsu, Ph.D.
Angela M. Neal-Barnett, Ph.D.
Claire Draucker, Ph.D., RN
Yoshinobu Hakutani, Ph.D.

Accepted by

____________________________________, Chair, Department of Psychology
Janis H. Crowther, Ph.D.
____________________________________, Dean, College of Arts and Sciences
Jerry D. Feezel, Ph.D.
# TABLE OF CONTENTS

LIST OF FIGURES ........................................................................................................... iv

LIST OF TABLES ............................................................................................................... v

ACKNOWLEDGMENTS ................................................................................................. vi

CHAPTER Page

1 INTRODUCTION ...................................................................................................1

2 METHOD ..............................................................................................................23

3 DATA ANALYSIS ..............................................................................................41

4 RESULTS ..............................................................................................................49

5 DISCUSSION ........................................................................................................81

REFERENCES .............................................................................................................94

APPENDIX

A MEASURES .............................................................................................................108
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Proposed Model</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>SBW Ideology as a Moderator of the Relationship Between Criterion A Trauma and Binge Eating Symptomatology</td>
<td>57</td>
</tr>
<tr>
<td>3</td>
<td>Originally Hypothesized Model – Full Sample</td>
<td>66</td>
</tr>
<tr>
<td>4</td>
<td>Final Model – Full Sample</td>
<td>70</td>
</tr>
<tr>
<td>5</td>
<td>Post Hoc Mediational Hypotheses</td>
<td>71</td>
</tr>
<tr>
<td>6</td>
<td>Final Model – High SBW Participants</td>
<td>76</td>
</tr>
<tr>
<td>7</td>
<td>Final Model – Low SBW Participants</td>
<td>78</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Descriptive Statistics for Measured Variables</td>
<td>42</td>
</tr>
<tr>
<td>2</td>
<td>Summary of Factor Analyses for Factors</td>
<td>45</td>
</tr>
<tr>
<td>3</td>
<td>Factor Names, Abbreviations, and Components</td>
<td>48</td>
</tr>
<tr>
<td>4</td>
<td>Correlation Matrix</td>
<td>50</td>
</tr>
<tr>
<td>5</td>
<td>Correlation Matrix – Demographic Variables and Factors</td>
<td>51</td>
</tr>
<tr>
<td>6</td>
<td>Hierarchical Regressions for Hypothesis 1</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>Hierarchical Regressions for Hypothesis 1 (All Variables Entered Simultaneously)</td>
<td>54</td>
</tr>
<tr>
<td>8</td>
<td>Summary of Hierarchical Regression Analyses for Hypothesis 2</td>
<td>56</td>
</tr>
<tr>
<td>9</td>
<td>Standardized Coefficients (and Standard Errors) of Paths in Analyses of the Mediating Effects of Support Seeking and Utilization, Emotional Inhibition and Regulation Difficulties, and Self-Silencing</td>
<td>59</td>
</tr>
<tr>
<td>10</td>
<td>Standardized Coefficients (and Standard Errors) of Paths in Analyses of the Mediating Effects of Eating for Psychological Reasons</td>
<td>62</td>
</tr>
<tr>
<td>11</td>
<td>Comparison of Nested Models for the Full Sample</td>
<td>67</td>
</tr>
<tr>
<td>12</td>
<td>Comparison of the Final Model for the Full Sample and High and Low SBW Participants</td>
<td>75</td>
</tr>
<tr>
<td>13</td>
<td>Unstandardized Path Coefficients for the Full Sample and High and Low SBW Participants</td>
<td>79</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

This dissertation represents a huge undertaking, and I owe a debt of gratitude to so many individuals whose help was invaluable during this process. My advisor and chair of my dissertation committee, Dr. Jan Crowther, believed in the merits of the project from its earliest inception, nurtured my ideas, and helped me translate them into reality. She has provided tremendous support, guidance, and mentoring to me during the many phases of my dissertation and throughout my time in graduate school. I have benefited greatly from her wisdom and investment in my professional development, and I am grateful for the time she has devoted to her mentorship of me.

I would also like to thank the members of my dissertation committee, Drs. T. John Akamatsu, Kristin Mickelson, Angela Neal-Barnett, Claire Draucker, and Yoshinobu Hakutani, whose insightful feedback helped shape my thinking and ultimately resulted in a better project. Special thanks to Dr. Mickelson for her considerable statistical expertise and willingness to answer my seemingly endless questions. In addition, Dr. Linda Sims at Summa Health Systems Hospital and the members of the Crowther Lab at Kent State University (especially Sheethal Reddy, Taryn Myers, and Marie LePage, who assisted with data collection) were crucial in helping me fine-tune and carry out the project.

Thanks also to my amazing friends for bringing such joy and laughter into my life and being there for me in countless ways. I’m especially grateful to Heather Henrickson,
my compañera for so many phases of graduate school – sharing the ride made the many hurdles much more bearable (and humorous). My family has also been a tremendous source of support and encouragement, and I feel so fortunate to have such a wonderful (and ever-expanding) group of people I call family. Thanks for always believing in me, being my biggest cheerleaders, and keeping me grounded. In particular, thank you to my parents for instilling in me the value of education, nurturing my curiosity about people and the world, and fostering my respect for all individuals and cultures.

Finally, I would like to thank the women who participated in this study for so freely and willingly sharing their time, experiences, and wisdom. Without them, this project literally would not have been possible. My hope is that this project will spur continued reflection, dialogue, and action so that we can work toward better understanding and serving the many individuals struggling with binge eating.
CHAPTER 1

INTRODUCTION

Binge eating, defined as the consumption of a considerable amount of food in a discrete time period accompanied by a sense of loss of control, is a widespread problem among African American women. Although definitive prevalence rates of binge eating in African American women are difficult to establish due to their underrepresentation in large-scale epidemiologic research, the studies that have examined binge eating in African American women suggest that binge eating is highly prevalent (e.g., Smith, 1995). Estimates of binge eating behavior have ranged from 8.4% to 34.3% (e.g., Payne & Harrington, 2002; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000), while estimates of the prevalence of Binge Eating Disorder (BED) among African American participants have ranged from 2.2% to 5% (Bruce & Agras, 1992; Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998).

In addition to being a widespread problem, recurrent binge eating is associated with a host of adverse emotional, psychological, and physical consequences, including guilt and shame; comorbid psychological problems and disorders (e.g., depression, anxiety, low self-esteem); impaired interoceptive awareness and signals of hunger and satiety; and increased risk of/association with obesity and its medical sequelae (e.g.,...
diabetes, cardiovascular disease, hypertension; Crowther & Harrington, 2006; Herrin, 2003). Given the prevalence of binge eating and its serious consequences, it is essential that we build an accurate, comprehensive understanding of how African American women come to develop and maintain binge eating in order to inform treatment and prevention efforts.

To date, there has been little effort to develop an understanding of the etiology of binge eating in African American women. Not only do we not have very good estimates of the prevalence of binge eating, but we also do not have any models to understand the development and maintenance of binge eating in this group of women. Instead, the literature has either tried to explain binge eating generically while overlooking the role of race/ethnicity, or has attempted to map onto African American women models that were originally developed to explain Caucasian women’s binge eating.

The principal goals of the present study, then, were to examine factors that may be related to binge eating in African American women and to empirically test a culturally specific model of binge eating (see Figure 1). Previous research has suggested that trauma, stress, and discriminatory stress are significantly related to the severity of African American women’s binge eating (Harrington, Crowther, Henrickson, & Mickelson, 2006). However, these variables were not significant predictors of the psychological function of eating, suggesting that their relationships with binge eating severity may be mediated by other factors not yet examined.

In the current model, therefore, the relationships among trauma, stress, discriminatory stress, and binge eating were hypothesized to be influenced by
Figure 1 *Proposed Model*

CAT = Criterion A Trauma
STR = Stress
DISC = Discriminatory Stress
SBW = Strong Black Woman Ideology
SUP = Support Seeking and Utilization
EI/RD = Emotional Inhibition/Regulation Difficulties
SIL = Self-Silencing
EPR = Eating for Psychological Reasons
BE = Binge Eating
endorsement and internalization of the Strong Black Woman (SBW) ideology, support
seeking and utilization, emotional inhibition and emotion regulation difficulties, and self-
silencing. Eating for psychological reasons was hypothesized to mediate the
relationships between each of these variables and binge eating symptomatology. To date,
virtually no empirical examination of these factors and how they may be related to binge
eating has been undertaken. Thus, the proposed study represents the first attempt to
investigate empirically these variables and to integrate them into the proposed model.
The literature on each of these constructs will be reviewed in detail in the remainder of
the introduction.

Trauma, Stress, Discriminatory Stress, and Binge Eating

Exposure to trauma or the experience of traumatic events has often been
implicated in the development of eating disorders. Studies have found significant
associations between eating disorders and several different types of trauma, including
child physical abuse and neglect (e.g., Rorty & Yager, 1996); dating violence (Ackard &
Neumark-Sztainer, 2002); sexual assault (e.g., Dansky, Brewerton, Kilpatrick, & O’Neil,
1997); and sexual harassment (Harned, 2000; Harned & Fitzgerald, 2002; Larkin, Rice, &
Russell, 1996). Perhaps the most widely investigated link between trauma and eating
disorders relates to a history of child sexual abuse (CSA). Estimates of CSA in women
with eating disorders have varied considerably; however, a conservative estimate is that
around 30% of patients with eating disorders have a history of CSA (Connors & Morse,
1993). Further, the general consensus is that CSA is best conceptualized as a nonspecific
risk factor for eating disorders, especially bulimia nervosa (de Groot & Rodin, 1999;
Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997). It also appears that experiencing multiple forms of child abuse further increases the risk for eating problems (Ackard, Neumark-Sztainer, Hannan, French, & Story, 2001; Rorty, Yager, & Rossootto, 1994).

Several explanations for the relationship between trauma and eating disorders have been offered. One useful way to conceptualize this link is to consider the function of the eating disorder symptoms. In other words, trauma may lead to various problems or deficits that eating disordered symptoms and behaviors attempt to address (albeit in a maladaptive fashion). For example, trauma may lead to difficulties with affect regulation; in turn, eating pathology (e.g., bingeing) may develop as a means of self-soothing or nurturing or as a means of managing negative affect (de Groot & Rodin, 1999; Schwartz & Gay, 1996). Another possible mechanism for the association between trauma and eating disorders relates to self-blame and self-punishment. Depending on the individual’s appraisal of the trauma (e.g., whether she internalizes blame for the event or events), she may develop eating disorder symptoms as a means of punishing herself; thus, symptoms such as fasting, bingeing, or purging may be an expression of self-harm (Schwartz & Gay, 1996). Other researchers have conceptualized eating problems as a coping or survival strategy in response to the trauma. Often the victim is in a powerless position and may have few resources available to her, and so eating disorder symptoms may develop as an originally logical response given the circumstances (Schwartz & Gay, 1996; Thompson, 1994). Eating disorder symptoms also may serve the function of distracting the victim from the emotional pain of the trauma or allowing her to escape
from her painful circumstances. In particular, bingeing may be a way in which the victim can induce a dissociative state in order to escape this pain temporarily, as dissociative experiences such as feeling numb or “spacing out” have been found to be common in episodes of bingeing (e.g., Gershuny & Thayer, 1999).

Stress is another variable that has been implicated in both the onset and maintenance of eating disorders. Prior research has found support for relationships between eating disorders and each of several different operational definitions of stress, including objective stressors (e.g., Troop & Treasure, 1997); subjective or perceived stress (e.g., Haslam, Stevens, & Haslam, 1989); stressful life events (e.g., Schmidt, Tiller, & Treasure, 1993); and daily hassles (e.g., Shatford & Evans, 1986). One fairly consistent finding is that women with eating disorders tend to perceive their lives as more stressful and report less tolerance for stress than women without eating disorders in both laboratory and naturalistic studies (Cattanach, Malley, & Rodin, 1988; Crowther, Sanftner, Bonifazi, & Shepherd, 2001; Hansel & Wittrock, 1997). Furthermore, stress has been linked to symptomatic behaviors such as bingeing in both laboratory and naturalistic studies (Lingswiler, Crowther, & Stephens, 1989; Tuschen-Caffier & Voegele, 1999). There is also evidence to suggest that stressful life events have etiological significance for some individuals with eating disorders. For example, in a study by Troop and Treasure (1997), 59% of AN-onset and 77% of BN-onset patients had an “event-provoked onset;” that is, the onset of their eating disorder could be traced to a stressful life event.
Similar to trauma and eating disorders, a useful way of conceptualizing the relationship between stress and eating disorders is to examine the function of eating symptoms. Some researchers have theorized that coping skills deficits lead individuals to develop eating disorder symptoms as maladaptive coping mechanisms. Thus, behaviors such as bingeing, purging, and so forth may be a way to reduce tension, avoid thinking about a stressful situation, or shift attention to something unrelated to the stressor (Heatherton & Baumeister, 1991). Eating disorder symptoms may also serve the function of managing or avoiding the negative affect associated with a stressor or escaping from aversive self-awareness (Heatherton & Baumeister, 1991).

There has been considerably less empirical investigation of the potential relationship between eating disorders and discriminatory stress, which refers to the stress associated with being treated in biased, prejudiced, or inequitable ways because of factors such as one’s race/ethnicity, sex, socioeconomic status, or sexual orientation. Previous research (Harrington et al., 2006; Landrine & Klonoff, 1996) has conceptualized the discriminatory stress construct as being comprised of objective components such as the number of discriminatory events experienced, as well as subjective components that relate to the individual’s appraisal of such events (i.e., the perceived stressfulness of discriminatory experiences). Although several researchers have hypothesized that discriminatory experiences (with particular emphasis on racist experiences) may be connected to eating problems (e.g., Root, 1990; Striegel-Moore & Smolak, 2000), to our knowledge only three studies have actually examined this potential association.
The first such study was Thompson’s (1994, 1996) qualitative investigation of women of color and lesbians with eating problems. A consistent finding from the interviews with the participants was that many of the women cited racist and sexist experiences as contributing to their eating problems. Thompson thus asserted that eating problems developed in these women as a function of the multiple oppressions (i.e., racism and sexism) they faced and as they searched for a coping or survival strategy for their difficult experiences, often from positions of little power and few resources. However, two methodological issues may have impacted the validity of Thompson’s findings. First, a snowball sampling technique was used to identify women who had been in recovery from their eating problems for at least one year; both the recruitment technique and the recovery requirement have implications for the representativeness of the sample and the generalizability of Thompson’s results. Second, data were gathered using an unstructured interview technique, raising the possibility of bias in the topics discussed and the extent to which they were explored.

The second study to examine a potential relationship between discriminatory experiences and eating disorders was conducted by Striegel-Moore, Dohm, Pike, Wilfley, and Fairburn (2002), who investigated whether rates of race-/ethnicity-based discrimination in childhood would be associated with increased risk for the development of psychopathology in general and BED in particular. White women with BED reported significantly higher rates of discrimination than psychiatric controls and healthy comparison participants. In contrast, the rates of discrimination reported by black women with BED did not significantly differ from those reported by either psychiatric controls or
healthy comparison participants, leading the authors to conclude that discrimination was neither a general nor a specific risk factor for BED among black women. This conclusion should be tempered by several considerations, however. First, discrimination was measured with a single item that only assessed objective elements (i.e., exposure) and did not include subjective components (i.e., appraisal); therefore, the reliability and validity of this measure of discrimination is questionable. Further, only retrospective recall of childhood discrimination was obtained. Given that the mean age of onset for BED was slightly over age 18 for the black women in the Striegel-Moore et al. study, it is quite possible that discrimination experienced in adulthood also influenced the risk for developing BED. Finally, the number of participants in the three groups of black female participants varied considerably, and in fact was quite small in the two control and comparison groups; as such, the study may have lacked sufficient power to detect true differences in discrimination among the groups.

In the third study examining discrimination and disordered eating, Harrington and colleagues (2006) investigated whether discriminatory stress (operationalized as the perceived stressfulness associated with experiences of racism and sexism) was associated with the severity of binge eating symptomatology. Results indicated that discriminatory stress was significantly related to the severity of binge eating among African American but not Caucasian participants (though the correlation was fairly small [$r = .22$]).

Although empirical investigation on the topic is still in its early stages, researchers have proposed several potential explanations as to why discriminatory experiences may be related to binge eating. Some of these proposed explanations overlap
with the suggested mechanisms linking trauma and stress to binge eating, such as self-soothing and self-nurturing; managing, avoiding, or escaping negative affect associated with the discriminatory experiences; blaming or punishing oneself; and attempting to cope with the stressor. Mechanisms that are more specific or unique to the relationship between discrimination and binge eating have also been proposed. For example, problems with binge eating may develop among women who have internalized negative stereotypes about women from their racial/ethnic group (e.g., West, 1995), or may be a way in which conflicts surrounding particular stages of ethnic identity development are played out (e.g., Harris & Kuba, 1997). Another potential mechanism involves body image disturbance and more specifically, dissatisfaction with racial/ethnic features that may be related to internalization of the dominant culture’s devaluation and denigration of these “non-white” characteristics.

In summary, prior research suggests relationships among trauma, stress, discriminatory stress, and binge eating. However, because the reasons for these relationships are typically inferred rather than directly measured and tested, the process by which these variables might be related to binge eating (i.e., potential moderating or mediating variables) is still unclear. Specifically, the factors that predict the function of binge eating among African American women remain unknown. One potential factor that may be moderating these relationships among trauma, stress, discriminatory stress, and binge eating is the image of the Strong Black Woman.
Strong Black Woman Ideology

The Strong Black Woman (SBW) is an extremely salient cultural symbol, both within and outside of African American communities (e.g., Harris-Lacewell, 2001; Randolph, 1997, 1999). One of the central tenets of the SBW symbol is that African American women are inherently strong and resilient; these are intrinsic, essential qualities, as are self-reliance and self-containment (Jones & Shorter-Gooden, 2003; Morgan, 1999). This symbol presumes a life marked by struggle and adversity, but also by survival and the ability to overcome that adversity. Underlying the SBW image are dictates to be strong and capable of handling everything, as well as admonishments against weakness or vulnerability. In addition to its imperatives of strength, the SBW symbol also highlights African American women’s role as caretakers; nurturing and preserving the family and community are emphasized as responsibilities of the utmost importance (Morgan, 1999; Romero, 2000).

The SBW symbol first originated in a particular historical and cultural context as a rationalization for and justification of slavery. The prevailing view of (white) women at the time was that they were fragile and weak, possessed delicate constitutions, and needed protection (hooks, 1993; Morgan, 1999). According to the “cult of true womanhood,” the Victorian ideals of femininity that predominated in that time period, women could be described as possessing four inherent characteristics: piety, purity, domesticity, and submissiveness (Brannon, 2005). The harsh demands of physical labor, the breaking up of families and separation from children, the physical punishments, and the sexual victimization that African American women experienced as slaves were
completely inconsistent with this image of womanhood, and thus it was necessary to set them apart from white women in order to maintain that slavery was a benign institution. Therefore, African American women were touted as being both physically and psychologically stronger and more resilient than white women (Harris-Lacewell, 2001; Morgan, 1999; Wallace, 1979). This conceptualization of African American women persisted after the end of slavery and became one of several stereotypical images of black women that permeated the dominant culture, along with the stereotypical images of Mammy (the dark-skinned, overweight, asexual, selfless, nurturing caretaker); Sapphire (the angry, aggressive, critical, nagging, and emasculating woman); and Jezebel (the hypersexual, promiscuous, immoral, sexually aggressive, and manipulative seductress; Thomas, Witherspoon & Speight, 2004; West, 1995).

Over time and in response to these derogatory images of black womanhood (and more contemporary manifestations, such as welfare queens and crack mothers), the image of the SBW was appropriated within the black community as African American women sought to define themselves in a positive light (Harris-Lacewell, 2001; Morgan, 1999). As a result, it has become both a cultural prescription and an expectation, used to both dictate and evaluate African American women’s behavior. African American girls are raised to be SBWs, and as part of the racial socialization process, they internalize the message that strength is imperative. As a result, strength becomes an integral component of black women’s racial identity and sense of authenticity (Harris-Lacewell, 2001; Morgan, 1999).
The SBW image is not inherently negative or detrimental. On the contrary, the image encompasses several positive characteristics, imbues a sense of pride steeped in a rich cultural and historical legacy, engenders confidence and self-efficacy for confronting life’s challenges, and provides a source of encouragement, reassurance, and inspiration during difficult times. Further, the SBW image has allowed African American women to engage in self-naming and self-definition and to embark on forging a positive conceptualization of themselves, rather than letting white culture define them in predominantly racist, negative terms (Harris-Lacewell, 2001; Morgan, 1999). However, the SBW image becomes problematic if during the socialization process, an African American woman not only internalizes and endorses the image but also comes to see its components as cultural mandates that are couched in ideal, excessive, and/or unrealistic terms; she is then vulnerable to some of the potentially harmful aspects of the SBW image (e.g., Mitchell & Herring, 1998). For example, underlying the image are pressures to live up to a “superwoman” ideal that may be difficult if not impossible to attain; judging oneself as falling short of these ideals can lead to feelings of shame, guilt, low self-esteem, and depression (Chisholm, 1996; Harris-Lacewell, 2001). Further, the SBW image in its ideal or excessive form does not allow black women to experience or express vulnerability, distress, or difficulty, and may also minimize or deny the struggles that black women face. As a result, African American women are not granted permission to feel stress or pain, to break down, or to struggle (Mitchell & Herring, 1998; Morgan, 1999). Thus, the SBW symbol has been described as being “simultaneously empowering and destructive” (Harris-Lacewell, 2001, p. 10).
Although the SBW image has frequently been discussed in conjunction with depression (e.g., Amankwaa, 2003; Danquah, 1998) and anxiety (Neal-Barnett, 2003), there has been extremely limited exploration of how this concept may be related to eating behavior. One exception is Beauboeuf-Lafontant’s (2003) theoretical investigation and discussion of the connection between the SBW symbol and African American women’s eating and weight. Beauboeuf-Lafontant posits that the cultural pressures to embody strength and control and the corollary prohibitions against weakness and vulnerability lead to an “erasure and denial of pain” (p. 115) that may leave many African American women susceptible to self-medicating with compulsive overeating. This possibility may be especially likely among African American women who see themselves as “mules of the world” (Neale Hurston, 1937) and “are overburdened and burden themselves with too much caring and responsibility for others” (Beauboeuf-Lafontant, 2003, p. 115). Thus, Beauboeuf-Lafontant asserts that there is a connection between the “emotional strain of having to minister to the needs of many” and the higher prevalence of overweight and obesity in African American women, stating that many of these women are symbolically “carrying the weight of the world on their bodies” (pp. 115-116). This idea that overidentification with or excessive internalization and endorsement of the SBW image may be connected to African American women’s eating behavior is an intriguing possibility, but it has not yet undergone empirical investigation. Further, the construct of SBW ideology has yet to be operationally defined and measured, and thus its potential relationships to variables such as eating behavior or emotional distress remain unclear.
Given the cultural dictates encompassed by the SBW image, it is likely to impact not only binge eating, but also variables such as support seeking and utilization, emotional inhibition and emotion regulation difficulties, and self-silencing behavior. In fact, these variables may provide the critical links between the SBW image and binge eating, perhaps as pathways increasing the likelihood of using eating for psychological reasons. In the following sections, the existing literature on each of these variables and their potential connections with binge eating will be reviewed.

Support Seeking and Utilization

Social support is a multidimensional construct that encompasses informational, instrumental, and emotional support, as well as both objective and subjective dimensions (i.e., received support vs. perceived availability of support). Most existing research has conceptualized social support as a buffer between life events and negative health outcomes, such that higher levels of social support mitigate the potentially adverse effects of stressful life events (e.g., Cohen & Wills, 1985). More recently, however, researchers have begun to acknowledge the dynamic, interactional nature of the relationship between life events and social support. From this conceptualization, life events and chronic stressors are thought to affect social support by eroding or depleting the network’s resources (e.g., Lepore, 1997).

Research has suggested that individuals with eating disorders perceive social support as less available than do individuals without eating disorders (e.g., Grisset & Norvell, 1992). Further, lower perceived support from peers has been found to predict disordered eating among college women in cross-sectional research (Tylka & Subich,
2004) and to predict prospectively the onset of body dissatisfaction and eating disorder symptomatology, including binge eating, among adolescent girls (Stice, Presnell & Spangler, 2002). In addition to serving as a risk factor for eating pathology, (perceived) social support deficits are also likely to interact with eating disorder symptomatology such that existing support is further eroded.

The SBW image’s heavy emphasis on self-sufficiency and “handling it all” likely has implications for support seeking and utilization. African American women who have internalized the cultural imperatives to be strong, capable, and invulnerable might be less likely to seek or utilize social support, even if they have such support available. There are several reasons why such women may be reluctant to seek out support. They may be embarrassed or ashamed if they cannot meet the standards of the SBW image; they may denigrate themselves for not being able to take care of the situation on their own; and they may fear negative evaluation from others for admitting to vulnerability and for seeking help.

*Emotional Inhibition and Emotion Regulation Difficulties*

Emotional inhibition refers to the restriction or suppression of either the experience or the expression of emotion. This construct is comprised of both the frequency with which negative feelings are held in and the frequency with which negative emotions are expressed outwardly. While emotional inhibition refers to the lack of emotional expression, emotion regulation refers to the awareness, understanding, and acceptance of emotions; the ability to modulate emotional arousal; and the ability to act
in desired ways irrespective of emotional state (e.g., refraining from impulsive behavior when emotionally aroused; Gratz & Roemer, 2004).

There is a substantial literature documenting associations between emotional inhibition and emotion regulation difficulties and eating pathology. One of the most dominant conceptualizations of binge eating is that the behavior represents a maladaptive attempt at regulating and managing negative affect (see Deaver, Miltenberger, Smyth, Meidinger, & Crosby, 2003, for a review). Considerable laboratory and naturalistic research has suggested that negative affect is a frequent trigger for binge episodes, which has led researchers to theorize that binge eating serves an affect regulation function such as self-soothing, emotional numbing, avoiding or distracting oneself from negative affect, or escaping aversive self-awareness (de Groot & Rodin, 1999; Gershuny & Thayer, 1999; Heatherton & Baumeister, 1991; Schwartz & Gay, 1996). With respect to emotional inhibition, a recent study by Zaitsoff, Geller, and Srikameswaran (2002) found that adolescents reporting high levels of eating disorder symptoms exhibited greater anger inhibition; in addition, anger inhibition significantly predicted both cognitive and behavioral eating disorder symptoms. Further, patients with anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified have evidenced significantly higher levels of alexithymia (which refers to difficulty identifying and expressing feelings and an avoidance of internal experience) than control participants (e.g., Cochrane, Brewerton, Wilson & Hodges, 1993; Jimerson, Wolfe, Franko, Covino, & Sifneos, 1994; Schmidt, Jiwany, & Treasure, 1993; Troop, Schmidt, & Treasure, 1995).
No research to date has examined emotional inhibition and regulation as it relates to the SBW image; however, given that the socialization process for African American women as related to the SBW image emphasizes containing and repressing emotions as a survival strategy and an indicator of strength (e.g., hooks, 1993; Mitchell & Herring, 1998), these factors are likely to be related. This ability to camouflage, deny, or suppress feelings is frequently framed as a sign of strong character (hooks, 1993). The SBW image encourages African American women to inhibit the experience and/or expression of negative emotions such as anger, sadness, and fear, because such emotions are incompatible with the pillar of strength mandate (e.g., Mitchell & Herring, 1998). Thus, women who have internalized the SBW imperatives would likely show greater levels of emotion regulation difficulties related to the inhibition and suppression of negative affect and the nonacceptance of negative, “off-limits” emotions.

Self-Silencing

Self-silencing refers to a set of cognitive schemas about the importance of establishing and maintaining relationships by engaging in behaviors such as prioritizing others’ needs, censoring and repressing genuine emotion, and adopting external standards of self-evaluation (Jack, 1991). Although this construct originated in the literature on women and depression as a sociocultural explanation for sex differences in depression, more recent research has begun to document relationships between self-silencing and
eating pathology. For example, Zaitsoff, Geller, and Srikameswaran (2002) found that adolescents reporting high levels of eating disorder symptoms exhibited greater tendencies to self-silence, to judge the self by external standards, and to present an outwardly compliant self (different facets of the self-silencing construct as outlined by Jack & Dill [1992]). Further, they found that self-silencing significantly predicted both cognitive and behavioral eating disorder symptoms in their sample. Similarly, Frank and Thomas (2003) found that externalized self-perceptions significantly predicted anorexic and bulimic dietary cognitions, while self-silencing significantly predicted bulimic dietary behaviors among college women. Smolak and Munstertieger (2002) also examined the relationships between self-silencing and eating pathology among college women, finding that externalized self-perceptions predicted binge eating and emotional eating when anxious, while externalized self-perceptions and self-silencing both predicted restrained eating and emotional eating when angry.

Implicitly underlying the dictates regarding the SBW’s responsibility to nurture and protect her family and community are messages that caretaking is of utmost importance, a focus on oneself and one’s own needs is selfish, and negative emotions should not be expressed to others. These messages are analogous to many of the tenets of the self-silencing construct. Thus, African American women who have excessively internalized the cultural imperatives of the SBW image would be likely to exhibit greater levels of self-silencing than those women who have not internalized the SBW image.

---

1 Currently there is a fair amount of controversy about whether the construct of self-silencing is exclusive to women. While an interesting and important concern, this issue is outside the scope of this paper; interested readers should refer to Cramer & Thoms (2003) and Smolak & Munstertieger (2002) for discussion of the debate.
Eating for Psychological Reasons

Eating for psychological reasons is a multidimensional construct that refers to using eating to fulfill psychological or emotional needs, such as providing comfort, tension reduction, or anger displacement. Researchers have operationalized this construct in different ways, including learned expectancies for reinforcement from eating (Hohlstein, Smith & Atlas, 1998); emotional eating (that is, using eating to cope with negative affect; Arnow, Kenardy & Agras, 1995); and a specific subset of eating for psychological reasons, eating in response to trauma (Harrington et al., 2006).

Overall, prior research suggests that eating for psychological reasons, regardless of how it is operationally defined, is a strong predictor of eating symptomatology. For example, eating expectancies have demonstrated the ability to discriminate eating disorder diagnostic groups from one another and from psychiatric and healthy controls in theoretically consistent ways (Hohlstein et al., 1998). Emotional eating is strongly associated with binge eating symptomatology (e.g., Arnow, Kenardy, & Agras, 1995) and significantly predicts reductions in binge eating following treatment (Arnow et al., 1995). Eating in response to trauma is also significantly associated with binge eating symptomatology; further, this construct has been shown to mediate the relationship between trauma and binge eating severity (Harrington, Crowther, Henrickson, & Shipherd, in preparation). Taken together, these findings suggest that there are many paths that might lead an individual to eating for psychological reasons, but once she has reached that point, there is a much greater likelihood that she will develop binge eating.
The Present Study

In the present study, then, eating for psychological reasons was hypothesized to mediate the relationships between SBW ideology, support seeking and utilization, emotional inhibition and regulation difficulties, self-silencing, and binge eating. This model builds on Beauboeuf-Lafontant’s (2003) assertion that overidentification with or excessive internalization and endorsement of the SBW image may be connected to African American women’s eating behavior. Specifically, in the current model, African American women who overinternalize and overidentify with the SBW image were hypothesized to respond to traumatic, stressful, and discriminatory experiences by failing to seek or utilize social support, inhibiting and failing to accept negative emotions, and continuing to prioritize others’ needs above their own, which increases the likelihood that they will use eating for psychological reasons, in turn rendering them more susceptible to binge eating. For these women who are adhering so closely to the SBW image’s prescriptions, then, food and eating become an outlet for dealing with traumatic and stressful experiences, the pressure to attain unrealistic ideals, and negative affect.

The model for the proposed study (see Figure 1) consisted of four hypotheses that tested these potential relationships:

1. Trauma, stress, and discriminatory stress will be significantly related to binge eating.

2. Endorsement of the Strong Black Woman (SBW) ideology will moderate the relationships between trauma, stress, discriminatory stress, and binge eating. Specifically, women endorsing high levels of SBW ideology will report greater
binge eating symptomatology with increasing exposure to and distress associated with traumatic, stressful, and discriminatory experiences.

3. Social support seeking and utilization, emotional inhibition and emotion regulation difficulties, and self-silencing will mediate the relationship between SBW ideology and eating for psychological reasons (i.e., SBW ideology will influence eating for psychological reasons through its effects on these three constructs).

4. Eating for psychological reasons will mediate the relationships between SBW ideology, support seeking and utilization, emotional inhibition and emotion regulation difficulties, self-silencing, and binge eating.
Participants

Participants were 200 women recruited from a clinic waiting room at a mid-sized urban hospital (29.8%, n = 59), faculty/staff mass mailings (13.1%, n = 26), undergraduate psychology courses at a large Midwestern university (49.0%, n = 97), and word-of-mouth (8.1%, n = 16). The mean age of the women was 30.55 (SD = 13.63, range 17 – 68), and the mean body mass index (BMI) was 28.33 (SD = 7.92, range 17.63 – 63.89). All of the women self-identified as African American or Black. With respect to the highest level of education obtained, the majority of the participants (60.5%) reported that they had attended some college, earned a trade school certificate, or earned an associate’s degree. Approximately one-quarter of the sample (24.0%) reported earning a high school diploma or less, while 15% reported earning a bachelor’s, master’s, or doctorate degree. A significant portion of the participants (44.5%) reported that they were not currently employed; approximately one-quarter reported being employed either part-time (23.5%) or full-time (24.0%), while 8.0% of the sample designated their employment status as “other” (e.g., full-time student). Almost half the participants (48.0%) reported personal incomes of less than $5000 annually, while 49.2% reported
household incomes of less than $25,000 annually. The majority of the women (64.5%) indicated that they had never been married; 13.5% were currently married, 14.0% separated or divorced, 2.5% widowed, and 3.0% living with their partner.

Measures (see Appendix A)

Demographic Form. Participants indicated their age, household composition, marital status, education level, employment status, and personal and household income. They also reported their height and weight, which were used to calculate BMI (derived using the following formula: weight [in pounds] multiplied by 703 divided by height [in inches] squared).

Trauma. The Life Stressors Checklist–Revised (LSC-R; Wolfe & Kimerling, 1997) assessed objective and subjective dimensions of trauma. The instrument asks participants to indicate whether they have experienced each of 30 events (e.g., car accident, physical abuse, natural disaster). For each positively endorsed event, respondents indicate the number of times they have experienced the event; their age at first occurrence; whether they believed they or someone else could be seriously hurt or killed; whether they experienced intense fear, helplessness, or horror at the time of the event; and their distress related to the event both at the time and during the past year on a 5-point Likert scale (“not at all” to “extremely”). The LSC-R yields two scores that represent objective and subjective dimensions of trauma: the Event Total, which corresponds to the number of traumatic events the participant has experienced in his/her lifetime and can range from 0 (no events endorsed) to 30 (all events endorsed); and the
Subjective Distress total, which represents the amount of trauma-related distress the participant reports and can range from 0 to 150, with higher scores indicating higher levels of trauma-related distress.

The LSC-R has demonstrated good test-retest reliability (intraclass correlations ranging from .77-.86; McHugo et al., 2005) as well as high convergent validity (i.e., correlation with event history from a structured interview for PTSD, considered the gold standard; Wolfe and Kimerling, 1997). Evidence of the instrument’s construct and predictive validity comes from its significant associations with global psychiatric distress, depressive symptoms, PTSD symptoms, and PTSD diagnosis (e.g., Kimerling, Clum, & Wolfe, 2000; McHugo et al., 2005).

The Sexual Experiences Survey (SES; Koss & Oros, 1982; Koss & Gidycz, 1985) was used to assess sexual victimization. The SES asks participants to indicate whether they have experienced each of 10 events that represent a range of sexual victimization experiences (e.g., gross sexual imposition, sexual battery, forced sexual intercourse). Rather than using these legally defined terms, though, the events assessed on the SES are described in behaviorally specific terms (e.g., “Did you have sexual intercourse when you didn’t want to because a male threatened or used some degree of physical force [twisting your arm, holding you down, etc.] to make you?”). Unlike the LSC-R, the SES does not assess the frequency of sexual victimization experiences, the participants’ age at such experiences, or the perceived stressfulness of each event. In the present study, this information was assessed by adding questions about frequency, age, and subjective distress to the SES using a format similar to the LSC-R. Thus, for each positively
endorsed event, respondents indicated the number of times they have experienced the event; their age at first occurrence; whether they believed they or someone else could be seriously hurt or killed; whether they experienced intense fear, helplessness, or horror at the time of the event; and their distress related to the event both at the time and during the past year on a 5-point Likert scale (‘not at all’ to ‘extremely’). After these revisions, the SES then yielded two scores representing objective and subjective dimensions of sexual victimization: the Sexual Victimization Event Total, which corresponds to the number of victimization events the participant has experienced in her lifetime and can range from 0 (no events endorsed) to 10 (all events endorsed); and the Sexual Victimization Subjective Distress total, which represents the amount of victimization-related distress the participant reports and can range from 0 to 50, with higher scores indicating higher levels of victimization-related distress. The SES is the most widely used measure of sexual victimization experiences. The measure has demonstrated excellent test-retest reliability ($r = .93$) and good convergent validity, as the correlation between women’s level of victimization as determined by the SES compared to a structured interview was .73 (Koss & Gidycz, 1985).

For both the LSC-R and the SES, only events meeting Criterion A requirements for a diagnosis of PTSD (i.e., only those events involving a threat to one’s life and accompanied by intense fear, helplessness, or horror) were analyzed for this study.

Stress. The Survey of Recent Life Experiences (SRLE; Kohn & Macdonald, 1992) assessed objective daily or chronic stress, operationalized as daily hassles in areas such as work, family, interpersonal relationships, time pressure, finances, and mundane
annoyances (e.g., car problems; difficulty dealing with modern technology). The instrument consists of 51 items inquiring about the number and kind of daily hassles that participants have experienced over the past month. Participants indicate the extent to which each hassle has been a part of their lives in the past month on a 4-point scale (“not at all part of my life” to “very much part of my life”). Total scores range from 51-204, with higher scores indicating higher levels of objective stress.

The SRLE has demonstrated excellent internal consistency, convergent validity, and equally high internal consistency for men and women (de Jong, Timmerman, & Emmelkamp, 1996). Its subscales are only modestly intercorrelated, suggesting that the SRLE is not merely measuring subjective distress or negative well-being (Kohn & Macdonald, 1992). In the present sample, the SRLE demonstrated excellent internal consistency (alpha coefficient = .93).

The Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) was used to assess subjective chronic stress. The PSS is comprised of 14 items that ask participants to indicate how frequently they have felt a certain way (e.g., overwhelmed, unable to control important things in their lives) on a 5-point scale ranging from “never” to “very often.” Scores range from 0 to 56, with higher scores indicating greater subjective stress. The PSS is a widely used instrument of nonspecific appraised stress with good internal consistency and test-retest reliability (≥ .70). The instrument has demonstrated convergent, divergent, and predictive validity (Cohen et al., 1983), and appears to function well across age, sex, and ethnicity of respondents (Cole, 1999). The
PSS exhibited marginal internal consistency in the present sample, with an alpha coefficient of .69.

*Discriminatory Stress.* The Schedule of Racist Events (SRE; Klonoff & Landrine, 1999; Landrine & Klonoff, 1996) was used to assess the stress associated with perceived racism. The instrument consists of 18 items that assess the frequency of specific racist events in the past year and over the lifetime (Recent and Lifetime Racist Events subscales) using a 6-point scale ranging from “never” to “almost all of the time.” For every event endorsed, participants indicate how stressful they perceived the event to be on a 6-point scale ranging from “not at all” to “extremely” (Appraised Racist Events subscale). Scores on the Recent and Lifetime subscales range from 18-108, with higher scores indicating a greater number of racist experiences; scores on the Appraised subscale range from 18-108, with higher scores indicating greater stressfulness associated with racist experiences. All three of the SRE subscales have demonstrated extremely high internal consistency coefficients (≥ .93), high split-half reliability coefficients (≥ .90), and concurrent validity (Klonoff & Landrine, 1999; Landrine & Klonoff, 1996). In the current sample, the SRE subscales demonstrated excellent internal consistency (alpha coefficients greater than .92).

The Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995) assessed the stress associated with perceived sexism. The SSE lists 20 specific instances of sexist discrimination; participants indicate how many times each instance has occurred in the past year and in their entire lives (Recent and Lifetime Sexist Events subscales) on a 6-point scale ranging from “never” to “almost all of the time.” Scores on the Recent and
Lifetime subscales range from 18-108, with higher scores indicating a greater number of sexist experiences. Unlike the SRE, the SSE does not provide a rating of the perceived stressfulness of each event. In the present study, this information was assessed by adding stressfulness ratings to the SSE using a format similar to the SRE. Thus, participants rated how stressful each endorsed event was for them on a 6-point scale ranging from “not at all” to “extremely” (Appraised Sexist Events subscale). Scores on the Appraised subscale can range from 18-108, with higher scores indicating greater stressfulness associated with sexist experiences.

Both the Lifetime (SSE-L) and Recent (SSE-R) scales have demonstrated high internal consistency (.92 and .90, respectively) and split-half reliability (.87 and .83, respectively); significant correlations between the SSE and life events and daily hassles provide evidence of convergent validity. Further, one of the strengths of the SSE is that it is appropriate for women of various ages, ethnicities, socioeconomic statuses, and educational levels. The SSE subscales demonstrated adequate internal consistency in the current sample (alpha coefficients greater than .90).

**SBW Ideology.** In order to assess the caretaking and strength components of the SBW ideology, the Mammy stereotype and Superwoman stereotype subscales from the Stereotypic Roles for Black Women Scale (SRBWS; Thomas et al., 2004) were used. The SRBWS is a 34-item scale that measures perceptions and stereotypes of African American women. The instrument is comprised of four subscales that correspond to prominent stereotypical images of African American women: Mammy, Jezebel, Sapphire, and Superwoman. Respondents indicate the degree to which they agree with each item
on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree;” higher scores indicate greater endorsement of that stereotypical image of African American women. Example items on the Mammy stereotype subscale include “I often put aside my own needs to help others” and “I should not expect nurturing from others;” sample items from the Superwoman stereotype subscale include “If I fall apart, I will be a failure” and “I tell others that I am fine when I am depressed or down.”

The SRBWS is a new instrument, and thus limited psychometric information is available. However, preliminary evidence indicates that the subscales possess moderate levels of internal consistency (alpha coefficients ranging from .52 to .72) and are moderately intercorrelated, suggesting that they measure related but distinct constructs. With respect to construct validity, the subscale assessing the Mammy stereotype exhibited a significant negative relationship to self-esteem, while scores on both the Superwoman and Mammy stereotype subscales made a significant independent contribution to the variance in self-esteem over and above that contributed by racial identity attitudes (Thomas et al., 2004). In the current sample, the Mammy stereotype subscale exhibited rather poor internal consistency (alpha coefficient = .64), which could be due to the fact the subscale is comprised of only six items. The Superwoman stereotype subscale exhibited adequate internal consistency (coefficient = .77).

To assess the self-sufficiency components of the SBW image, the Efficacy of Help-Seeking Scale (EHSS; Eckenrode, 1983) was utilized. The EHSS is a 6-item scale that was developed to assess respondents’ “beliefs in the benefits versus costs of seeking and accepting help from others” (p. 516). Participants indicate the degree to which they
agree with each item on a 4-point Likert scale, ranging from “strongly agree” to “strongly disagree;” lower scores indicate lower beliefs in the efficacy or benefits of seeking and accepting help. Sample items include, “Admitting hardships to others is a sign of weakness” and “Accepting help from others makes you feel like you owe them something in return.” The EHSS has demonstrated modest levels of internal consistency (alpha coefficients ranging from .60-.70; Eckenrode, 1983; Keisler, 1997; Wright, 2000) in previous studies. The scale has demonstrated significant relationships with internal locus of control and has yielded improved prediction of support network mobilization in the face of stressful life events (Eckenrode, 1983). Further evidence of the measure’s construct validity is that support network mobilization has been shown to be related to greater levels of negative affect for individuals with negative help-seeking beliefs and less negative affect for those with positive help-seeking beliefs as measured by the EHSS (Riley & Eckenrode, 1986). The EHSS demonstrated comparable internal consistency in the present sample (alpha coefficient = .62) as in prior research.

Social Support Seeking and Utilization. A modified version of the UCLA Social Support Inventory (UCLA-SSI; Dunkel-Schetter, Feinstein, & Call, 1986) assessed both participants’ actual support seeking behavior and their willingness to seek support. The modified measure consists of five items that assess actual support seeking; for each potential source of support listed (e.g., spouse/partner, relatives, friends), participants indicate how often they have sought various kinds of support (e.g., informational, instrumental, and emotional) over the past 6 months on a 5-point scale ranging from “never” to ‘very often.” In addition, the modified UCLA-SSI contains six items that
assess willingness to seek support; for each potential source of support listed (e.g., spouse/partner, relatives, friends), participants indicate how willing they are to seek various kinds of support (e.g., informational, instrumental, emotional) on a five-point scale ranging from “not at all” to “very.” Responses are summed across items to yield a total Support Seeking (SS) score and a total Willingness to Seek Support (WTSS) score; higher scores indicate greater support seeking or willingness to seek support.

*Emotional Inhibition and Emotion Regulation Difficulties.* The Courtauld Emotional Control Scale (CECS; Watson & Greer, 1983) assessed emotional inhibition. The CECS consists of 21 items assessing the extent to which participants report controlling their reactions when experiencing a particular emotion. Each item consists of an emotion stem (e.g., “When I feel unhappy…”) and a particular reaction (e.g., “I bottle it up”); participants are asked to indicate how often they respond to the emotion in question with such a reaction using a 4-point Likert scale ranging from “almost never” to “almost always.” The CECS is comprised of three subscales (Anger, Depressed Mood, and Anxiety), and yields scores on each of the subscales as well as a total score of inhibition of negative emotion.

The CECS has demonstrated good internal consistency (alpha coefficients ranging from .86 to .88) and temporal stability (test-retest correlations over 3-4 weeks for the subscales: .84-.89 and for the total score: .95). Regarding concurrent validity, the measure has demonstrated significant negative correlations with Type A behavior, indicating that individuals low on emotional control were more likely to engage in Type
A behavior (Watson & Greer, 1983). The CECS exhibited good internal consistency in the present sample (alpha coefficient = .84).

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) assessed difficulties in multiple domains of emotion regulation. The DERS contains 36 items measuring six domains of emotion regulation that correspond to the measure’s six subscales: Nonacceptance of Emotional Responses (NONACCEPTANCE); Difficulties Engaging in Goal-Directed-Behavior (GOALS); Impulse Control Difficulties (IMPULSE); Lack of Emotional Awareness (AWARENESS); Limited Access to Emotion Regulation Strategies (STRATEGIES); and Lack of Emotional Clarity (CLARITY). Participants are asked to indicate how often each item applies to them on a 5-point scale ranging from “almost never” to “almost always.” Higher scores on each subscale indicate greater difficulties with emotion regulation in that domain (e.g., higher scores on NONACCEPTANCE indicate greater difficulty with accepting one’s emotions). Only the NONACCEPTANCE and STRATEGIES subscales were used in the present study.

Although the DERS is a newly developed instrument, preliminary investigations have suggested that it possesses good psychometric properties. The overall DERS demonstrated high internal consistency (alpha coefficient = .93) and good test-retest reliability ($r = .88$), while all of the measure’s subscales exhibited adequate internal consistency (all coefficients > .80) and adequate test-retest reliability ($rs$ ranging from .57 to .89). The significant correlations between the DERS and measures of experiential avoidance and emotional expressivity provide evidence of construct validity, as does the
measure’s significant associations with the Generalized Expectancy for Negative Mood Regulation Scale, a commonly used measure of emotion regulation. Further, the DERS subscales exhibited differential and theoretically consistent patterns of association with these constructs. Evidence of the criterion validity of the DERS can be seen in its significant positive correlations with two behavioral outcomes conceptualized as being related to emotion dysregulation, deliberate self-harm and, among men, intimate partner abuse. Again, the DERS subscales exhibited differential and theoretically consistent patterns of association with these constructs. Only the Nonacceptance and Strategies subscales were used in the present analyses; these subscales each demonstrated adequate internal consistency in the present sample (alpha coefficients of .88 and .82, respectively).

*Self-Silencing.* The Silencing the Self Scale (STSS; Jack & Dill, 1992) assessed cognitive schemas about establishing and maintaining relationships and the behaviors thought to be associated with relationship building and maintenance (e.g., inhibiting particular feelings and actions). The STSS contains 31 items that comprise four subscales measuring the key dimensions of self-silencing: 1) externalized self-perception; 2) care as self-sacrifice; 3) silencing the self; and 4) the divided self. Participants indicate the degree to which they agree with each statement (e.g., “I don’t speak my feelings in an intimate relationship when I know they will cause disagreement”) using a 5-point scale ranging from “strongly disagree” to “strongly agree.” Scores can range from 31-155, with higher scores indicating greater endorsement of the measured construct (i.e., higher
scores on External Self-Perception indicate a greater tendency to judge oneself by external standards).

The STSS has demonstrated high test-retest reliability (rs ranging from .88-.93 in three different samples of women). Further, both the STSS total score (alpha coefficients ranging from .86 to .94) and the majority of the subscales (coefficients ranging from .74 to .90) have demonstrated good internal consistency. The one exception is subscale 2 (Care as Self-Sacrifice), where alpha coefficients ranged from .60-.81 across three different samples. Significant correlations between the STSS and measures of depression, as well as predicted mean differences in STSS scores across women in varying social contexts (undergraduate students, substance-abusing mothers, and battered women), provide evidence of the measure’s construct validity (Jack & Dill, 1992). The internal consistency of the STSS subscales was quite variable in the present sample. The Externalized Self-Perception and Silencing the Self subscales demonstrated adequate internal consistency estimates (alpha coefficients of .83 and .73, respectively), while the Care as Self-Sacrifice and Divided Self subscales exhibited poor internal consistency (coefficients of .52 and .57, respectively). The lower estimates for the two subscales could be due to the fact that they were comprised of 7-9 items each, though it should be noted that the other two subscales that demonstrated acceptable internal consistency were comprised of a similar number of items.

_Eating for Psychological Reasons._ Three measures were used to assess eating for psychological reasons. The Eating Expectancies Inventory (EEI; Hohlstein, Smith, & Atlas, 1998) assessed the function of eating. The EEI is comprised of 34 items that
measure five learned expectations for reinforcement from eating and dieting; these learned expectations correspond to the measure’s five subscales: Eating Helps Manage Negative Affect (I); Eating is Pleasurable and Useful as a Reward (II); Eating Leads to Feeling Out of Control (III); Eating Enhances Cognitive Competence (IV); and Eating Alleviates Boredom (V). Participants indicate the degree to which they agree with each EEI item using a 7-point scale (“completely disagree” to “completely agree”). The EEI does not yield a total score, but instead yields a score for each of the five subscales; higher scores indicate greater endorsement of the measured construct (e.g., higher scores on I indicate greater endorsement of eating managing negative affect). There is evidence of acceptable internal consistency (Cronbach’s alphas ranging from .78-.94) for each of the EEI subscales, as well as construct validity in that the EEI subscales correlate with eating disorder symptomatology in theoretically consistent ways and can differentiate individuals with varying levels and kinds of eating disturbances. Evidence of the EEI’s discriminant validity can be seen in the significant score differences between eating disorder patients and psychiatric controls, which suggests that the EEI scores do not reflect general psychiatric distress. Only EEI subscales I and III were used in the present study. The EEI-I subscale demonstrated excellent internal consistency (alpha coefficient = .91), while the EEI-III subscale demonstrated rather poor internal consistency (coefficient = .61), which is likely due to the fact that the subscale is comprised of only four items.

The Eating in Response to Trauma scale (ERT; Harrington et al., 2006) assessed using food and eating to cope with traumatic events. The ERT is comprised of 9 items
that measure the tendency to use eating as a means of coping with trauma; sample items include, “I eat to get away from intrusive thoughts or images” and “Eating can be a way to create a smaller or larger body so I can protect myself.” Participants indicate the degree to which they agree with each item using a 7-point scale (“completely disagree” to “completely agree”). ERT scores can range from 9-63, with higher scores indicating greater endorsement of eating in response to trauma.

Because the ERT is an extremely new instrument, limited psychometric information is available. However, preliminary data suggest that its internal consistency is high (alpha coefficient = .92) and the evidence for construct validity is encouraging. Specifically, ERT scores demonstrated significant relationships with both the number of traumatic events and the subjective distress associated with those events for general trauma, as well as three specific types/refinements of trauma: interpersonal trauma, sexual victimization, and Criterion A trauma (Harrington et al., in preparation). Further, ERT scores were strongly predictive of the severity of binge eating symptomatology, and mediated the relationships between general trauma and binge eating severity and between interpersonal trauma and binge eating severity (Harrington et al., in preparation). In the present sample, the ERT scale demonstrated excellent internal consistency (alpha coefficient = .93).

The Emotional Eating Scale (EES; Arnow, Kenardy & Agras, 1995) assessed coping with negative affect by eating. The EES consists of a list of 25 emotions (e.g., resentful, excited, worried); participants are asked to indicate the extent to which each emotion leads them to feel an urge to eat on a 5-point scale ranging from “no desire to
“eat” to “an overwhelming urge to eat”. In addition to a total score, the EES yields scores on three subscales: Anger/Frustration (EES-A/F), Anxiety (EES-A), and Depression (EES-D). The EES has demonstrated acceptable test-retest reliability ($r = .79$) and internal consistency (alpha coefficients: total = .81; EES-A/F = .78; EES-A = .78; and EES-D = .72). The significant correlations between EES scores and binge eating severity provide evidence of construct validity, while the significant correlations between changes in the EES subscales and treatment-related changes in binge eating demonstrate the measure’s criterion validity. With respect to discriminant validity, the EES was able to discriminate individuals who binge eat from individuals with anxiety disorders. Further, the instrument was not significantly related to depression, self-esteem, or general psychopathology (Arnow et al., 1995). The total score for the EES was used in the present sample; this score demonstrated excellent internal consistency (alpha coefficient = .95).

**Binge Eating.** The Binge Eating Scale (BES; Gormally, Black, Daston, & Rardin, 1982) was used to assess the affective, behavioral, and cognitive components of binge eating. The BES is comprised of 16 items that are presented as groups of three or four statements; participants are asked to indicate which statement best describes them. Scores range from 0-46, with higher scores indicating greater severity of binge eating symptomatology. The BES has good psychometric properties and is the most widely used measure to assess for Binge Eating Disorder (Marcus, Wing, & Lamparski, 1985). In the present sample, the BES demonstrated adequate internal consistency (alpha coefficient = .87).
The Eating Disorder Diagnostic Scales (EDDS; Stice, Telch & Rizvi, 2000) assessed eating disorder symptomatology. The EDDS is comprised of 22 items measuring the symptoms for anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV [4th ed.]; American Psychiatric Association, 1994). The items, which were adapted from structured psychiatric interviews such as the Eating Disorders Examination (Fairburn & Cooper, 1993) and the eating disorder module of the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon & First, 1990), assess cognitive (e.g., fear of weight gain) and behavioral (e.g., purging) eating disorder symptoms, as well as current height and weight, the number of missed menstrual periods in the past three months, and the use of oral contraceptives in the past three months. The response format varies by item; participants are either asked to provide dichotomous (yes/no) responses, indicate the number of days or times per week a particular behavior has occurred, or indicate their endorsement of cognitive symptoms using a 7-point Likert scale ranging from 0 (“not at all”) to 6 (“extremely”). The EDDS generates diagnoses for AN, BN, and BED. Further, items can be standardized and summed to yield an overall eating disorder symptom composite.

Eating disorder diagnoses generated by the EDDS have demonstrated adequate one-week test-retest reliability, with agreement between diagnoses at both time points ranging from 89-98%. The EDDS symptom composite has also demonstrated acceptable temporal stability over a one-week interval ($r = .87$), as well as acceptable internal consistency (mean alpha coefficient = .89). The high concordance between diagnoses
generated by the EDDS and those generated from structured interviews (range: 93-99%) provides evidence of the measure’s criterion validity (Stice et al., 2000). With respect to convergent validity, the EDDS symptom composite has demonstrated significant relationships of medium to large effect sizes with dietary restraint, disinhibited eating, and eating, weight, and shape concerns and rituals; further, individuals identified as eating disordered by the EDDS exhibited significantly elevated levels of these variables compared to individuals identified as non-eating disordered (Stice et al., 2000). Finally, the EDDS has also demonstrated predictive validity, as both the diagnoses and the symptom composite scores generated by the measure have been found to predict both response to an eating disorder prevention program and later onset of eating pathology and depressive symptomatology (Stice, Fisher & Martinez, 2004). Only the binge symptom composite was used in the present analyses; this composite demonstrated adequate internal consistency (alpha coefficient = .71).

**Procedure**

Following informed consent, participants completed the questionnaires individually or in small groups; average time of completion was approximately one hour. Upon completion of the booklets, women were either given credit for their psychology course (for college student participants; \( n = 97 \)) or paid $10 (for non-student participants; \( n = 103 \)).
CHAPTER 3

DATA ANALYSES

Preliminary Analyses

Descriptive statistics were calculated to examine the distribution of scores on each of the variables (see Table 1). Five variables (LSC-R Subjective Distress, SES Event Total, SES Subjective Distress, SRE-Recent, and SSE-Recent) exhibited non-normal distributions, with skewness values all greater than 1.5 and kurtosis values all greater than 4. Log transformations were performed on each of these variables, after which each exhibited normal distributions of scores and skewness and kurtosis values well within the acceptable range. Next, any outliers (defined as cases with scores of ± 3 SD from the mean on any variable) were identified and removed, resulting in the deletion of seven cases. Thus, the final sample consisted of 193 participants.

Creation of Factor Scores

Nine factors, derived from nine separate exploratory factor analyses, were created to represent key constructs.¹ The components for each factor analysis were selected a

¹ The factor analytic procedure was selected over summing the components because it allows for the weighted contribution of each item, an advantage relevant when more than two components comprise a factor (when only two components comprise a factor, the factor analysis procedure is equivalent to summing the components). Exploratory factor analyses were used to create all factors, whether comprised of two or three components, to maintain consistency. In all factor analyses, items were considered to load on a factor if the factor loading exceeded .40.
Table 1

*Descriptive Statistics for Measured Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion A Trauma (CAT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSC-R Criterion A Event Total</td>
<td>5.10 (4.22)</td>
<td>0 – 28</td>
<td>1.46</td>
<td>3.99</td>
</tr>
<tr>
<td>LSC-R Subjective Distress</td>
<td>16.54 (17.30)</td>
<td>0 – 140</td>
<td>2.93</td>
<td>14.56</td>
</tr>
<tr>
<td>SES Criterion A Event Total</td>
<td>0.73 (1.47)</td>
<td>0 – 10</td>
<td>2.89</td>
<td>10.54</td>
</tr>
<tr>
<td>SES Subjective Distress</td>
<td>2.38 (6.07)</td>
<td>0 – 50</td>
<td>4.27</td>
<td>23.45</td>
</tr>
<tr>
<td><strong>Stress (STR)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRLE</td>
<td>102.07 (25.30)</td>
<td>59 – 202.98</td>
<td>0.69</td>
<td>0.85</td>
</tr>
<tr>
<td>PSS</td>
<td>27.83 (6.40)</td>
<td>5.38 – 43</td>
<td>-0.46</td>
<td>0.33</td>
</tr>
<tr>
<td><strong>Discriminatory Stress (DISC)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRE-R</td>
<td>31.82 (14.98)</td>
<td>18 – 108</td>
<td>2.09</td>
<td>5.28</td>
</tr>
<tr>
<td>SRE-A</td>
<td>42.06 (19.83)</td>
<td>17 – 102</td>
<td>0.73</td>
<td>-0.03</td>
</tr>
<tr>
<td>SSE-R</td>
<td>34.70 (15.30)</td>
<td>20 – 120</td>
<td>2.09</td>
<td>6.41</td>
</tr>
<tr>
<td>SSE-A</td>
<td>38.65 (18.47)</td>
<td>19 – 114</td>
<td>1.28</td>
<td>1.86</td>
</tr>
<tr>
<td><strong>SBW Ideology (SBW)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EHSS</td>
<td>17.03 (3.10)</td>
<td>7 – 23</td>
<td>-0.46</td>
<td>0.01</td>
</tr>
<tr>
<td>“Mammy” Stereotype</td>
<td>15.34 (3.73)</td>
<td>5 – 25</td>
<td>0.01</td>
<td>0.08</td>
</tr>
<tr>
<td>“Superwoman” Stereotype</td>
<td>36.66 (8.43)</td>
<td>16 – 59</td>
<td>0.21</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Support Seeking and Utilization (SUP)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSB Total</td>
<td>9.48 (2.56)</td>
<td>0 – 15.70</td>
<td>-0.21</td>
<td>0.81</td>
</tr>
<tr>
<td>WTSS Total</td>
<td>12.49 (3.66)</td>
<td>4.30 – 27.50</td>
<td>0.38</td>
<td>0.91</td>
</tr>
</tbody>
</table>
Table 1 (Continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Inhibition and Regulation Difficulties (EI/RD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CECS Total</td>
<td>51.59 (11.42)</td>
<td>24 – 81</td>
<td>0.10</td>
<td>0.03</td>
</tr>
<tr>
<td>DERS-Nonacceptance</td>
<td>12.79 (5.47)</td>
<td>6 – 27</td>
<td>0.74</td>
<td>-0.16</td>
</tr>
<tr>
<td>DERS-Strategies</td>
<td>17.49 (6.29)</td>
<td>8 – 40</td>
<td>0.77</td>
<td>0.28</td>
</tr>
<tr>
<td>Self-Silencing (SIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalized Self-Perception</td>
<td>15.27 (5.46)</td>
<td>6 – 30</td>
<td>0.32</td>
<td>-0.54</td>
</tr>
<tr>
<td>Care as Self-Sacrifice</td>
<td>25.38 (5.22)</td>
<td>12 – 43</td>
<td>-0.01</td>
<td>0.24</td>
</tr>
<tr>
<td>Silencing the Self</td>
<td>23.53 (6.34)</td>
<td>9 – 44</td>
<td>0.10</td>
<td>-0.28</td>
</tr>
<tr>
<td>Divided Self</td>
<td>18.40 (4.87)</td>
<td>11 – 33</td>
<td>0.48</td>
<td>-0.36</td>
</tr>
<tr>
<td>Eating for Psychological Reasons (EPR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EEI-I</td>
<td>46.70 (21.11)</td>
<td>18 – 115.88</td>
<td>0.88</td>
<td>0.26</td>
</tr>
<tr>
<td>EEI-III</td>
<td>10.97 (5.29)</td>
<td>4 – 27</td>
<td>0.66</td>
<td>0.01</td>
</tr>
<tr>
<td>ERT</td>
<td>17.91 (11.32)</td>
<td>9 – 60</td>
<td>1.47</td>
<td>1.61</td>
</tr>
<tr>
<td>EES-Total</td>
<td>0 (1)</td>
<td>-0.99 – 4.06</td>
<td>1.48</td>
<td>2.33</td>
</tr>
<tr>
<td>Binge Eating Symptomatology (BE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BES</td>
<td>9.66 (8.50)</td>
<td>0 – 39</td>
<td>1.30</td>
<td>1.36</td>
</tr>
<tr>
<td>Binge Eating Symptom Composite</td>
<td>5.70 (6.15)</td>
<td>0 – 29</td>
<td>1.48</td>
<td>2.26</td>
</tr>
</tbody>
</table>

Note. LSC-R = Life Stressors Checklist–Revised; SES = Sexual Experiences Survey; SRLE = Survey of Recent Life Experiences; PSS = Perceived Stress Scale; SRE-R and -A = Schedule of Racist Events–Recent and Appraised; SSE-R and -A = Schedule of Sexist Events–Recent and Appraised; EHSS = Efficacy of Help-Seeking Scale; SSB = Support-Seeking Behavior; WTSS = Willingness to Seek Support; CECS = Courtauld Emotional Control Scale; DERS = Difficulties in Emotion Regulation Scale; EEI = Eating Expectancies Inventory; ERT = Eating in Response to Trauma; EES = Emotional Eating Scale; BES = Binge Eating Scale
priori on the basis of theoretical and conceptual expectations of the measures or subscales that would comprise each construct. Table 2 indicates the measures included in each factor analysis, their factor loadings, the eigenvalue, and the percentage of variance accounted for by the factor; only one factor emerged for each set of analyses. The Criterion A Trauma factor (CAT) is comprised of the Criterion A Event Total and Subjective Distress scores from the LSC-R and SES; thus, the factor consists of both objective and subjective elements, and serves as an index of each participant’s exposure to Criterion A traumatic events and the distress associated with those events. The Stress factor (STR; SRLE and PSS total scores) is also comprised of objective and subjective elements and represents both the amount and kinds of stressors experienced by each participant and her appraisal of those stressors. The Discriminatory Stress factor (DISC; SRE and SSE Recent and Appraised subscales) represents participants’ experiences of racist and sexist discrimination and the subjective distress associated with these experiences. The SBW Ideology factor (SBW; EHSS Total, “Mammy” and “Superwoman” Stereotype Scores) is comprised of elements addressing the caretaking, strength, and self-sufficiency aspects of the SBW image and represents participants’ endorsement and internalization of expectations to embody these characteristics. The Support Seeking and Utilization factor (SUP) is comprised of the UCLA-SS and UCLA-WTSS subscales, and represents the extent to which participants actually seek and are willing to seek social support. The Emotional Inhibition and Regulation Difficulties factor (EI/RD; CECS Total, DERS – Nonacceptance and DERS – Strategies scores) represents participants’ tendencies to suppress, have difficulty accepting, and have
### Table 2

*Summary of Factor Analyses for Factors*

<table>
<thead>
<tr>
<th>Factor Analysis</th>
<th>Factor Loading</th>
<th>Eigenvalue</th>
<th>Percent Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion A Trauma (CAT)</td>
<td></td>
<td>2.95</td>
<td>73.84%</td>
</tr>
<tr>
<td></td>
<td>LSC-R Criterion A Event Total</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LSC-R Subjective Distress</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SES Criterion A Event Total</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SES Subjective Distress</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>Stress (STR)</td>
<td></td>
<td>1.46</td>
<td>73.09%</td>
</tr>
<tr>
<td></td>
<td>SRLE</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSS</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td>Discriminatory Stress (DISC)</td>
<td></td>
<td>3.12</td>
<td>78.11%</td>
</tr>
<tr>
<td></td>
<td>SRE-R</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SRE-A</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSE-R</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSE-A</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>SBW Ideology (SBW)</td>
<td></td>
<td>1.82</td>
<td>60.73%</td>
</tr>
<tr>
<td></td>
<td>EHSS</td>
<td>-.53</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Mammy” Stereotype</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Superwoman” Stereotype</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSB Total</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WTSS Total</td>
<td>.93</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 (Continued)

<table>
<thead>
<tr>
<th>Factor Analysis</th>
<th>Factor Loading</th>
<th>Eigenvalue</th>
<th>Percent Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Inhibition and Regulation Difficulties (EI/RD)</td>
<td></td>
<td>1.96</td>
<td>65.37%</td>
</tr>
<tr>
<td>CECS Total</td>
<td>.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DERS-Nonacceptance</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DERS-Strategies</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Silencing (SIL)</td>
<td></td>
<td>2.45</td>
<td>61.26%</td>
</tr>
<tr>
<td>Externalized Self-Perception</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care as Self-Sacrifice</td>
<td>.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silencing the Self</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divided Self</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating for Psychological Reasons (EPR)</td>
<td></td>
<td>2.75</td>
<td>68.78%</td>
</tr>
<tr>
<td>EEI-I</td>
<td>.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EEI-III</td>
<td>.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ERT</td>
<td>.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EES-Total</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge Eating Symptomatology (BE)</td>
<td></td>
<td>1.60</td>
<td>79.78%</td>
</tr>
<tr>
<td>BES</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge Eating Symptom Composite</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.*  LSC-R = Life Stressors Checklist–Revised; SES = Sexual Experiences Survey; SRLE = Survey of Recent Life Experiences; PSS = Perceived Stress Scale; SRE-R and -A = Schedule of Racist Events–Recent and Appraised; SSE-R and -A = Schedule of Sexist Events–Recent and Appraised; EHSS = Efficacy of Help-Seeking Scale; SSB = Support-Seeking Behavior; WTSS = Willingness to Seek Support; CECS = Courtauld Emotional Control Scale; DERS = Difficulties in Emotion Regulation Scale; EEI = Eating Expectancies Inventory; ERT = Eating in Response to Trauma; EES = Emotional Eating Scale; BES = Binge Eating Scale
difficulty coping with negative affect. The Self-Silencing factor (SIL) is comprised of the four STSS subscales (Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, and the Divided Self) and represents the degree to which participants endorse the importance of establishing and maintaining relationships by engaging in behaviors such as prioritizing others’ needs, censoring and repressing genuine emotion, and adopting external standards of self-evaluation. The Eating for Psychological Reasons factor (EPR; EEI-I, EEI-III, ERT, and EES scores) represents the degree to which each participant uses eating to fulfill psychological functions. Finally, the Binge Eating Symptomatology factor (BE; BES total and EDDS – Binge Symptom Composite) represents the presence and severity of binge eating pathology and associated features (e.g., experiencing guilt and shame after binge episodes) among each participant. For a summary of the factors, the corresponding abbreviations, and components, see Table 3.

---

2 When a factor analysis was conducted on all the components of the above-mentioned factor analyses (e.g., all of the measures or subscales used in the study), results suggested minimal cross-loadings and were generally consistent with the factor structure proposed, with one exception – the stress and emotional inhibition/regulation difficulties components comprised one factor rather than two distinct factors, yielding a total of eight rather than nine factors. Factor loadings, eigenvalues, and percentage of variance accounted for by each factor for this factor analysis can be provided upon request. Given that this factor analysis generally provided support for the nine theoretically and conceptually driven factor analyses described above, the original factors were used in all subsequent analyses.
Table 3

*Factor Names, Abbreviations, and Components*

<table>
<thead>
<tr>
<th>Criterion A Trauma (CAT)</th>
<th>Emotional Inhibition and Regulation Difficulties (EI/RD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSC-R Criterion A Event Total</td>
<td>CECS Total</td>
</tr>
<tr>
<td>LSC-R Subjective Distress</td>
<td>DERS-Nonacceptance</td>
</tr>
<tr>
<td>SES Criterion A Event Total</td>
<td>DERS-Strategies</td>
</tr>
<tr>
<td>SES Subjective Distress</td>
<td><strong>Self-Silencing (SIL)</strong></td>
</tr>
<tr>
<td><strong>Stress (STR)</strong></td>
<td><strong>Externalized Self-Perception</strong></td>
</tr>
<tr>
<td>SRLE</td>
<td>Care as Self-Sacrifice</td>
</tr>
<tr>
<td>PSS</td>
<td>Silencing the Self</td>
</tr>
<tr>
<td><strong>Discriminatory Stress (DISC)</strong></td>
<td><strong>Divided Self</strong></td>
</tr>
<tr>
<td>SRE-R</td>
<td><strong>Eating for Psychological Reasons (EPR)</strong></td>
</tr>
<tr>
<td>SRE-A</td>
<td>EEI-I</td>
</tr>
<tr>
<td>SSE-R</td>
<td>EEI-III</td>
</tr>
<tr>
<td>SSE-A</td>
<td>ERT</td>
</tr>
<tr>
<td><strong>SBW Ideology (SBW)</strong></td>
<td><strong>Binge Eating Symptomatology (BE)</strong></td>
</tr>
<tr>
<td>EHSS</td>
<td>EES-Total</td>
</tr>
<tr>
<td>“Mammy” Stereotype</td>
<td><strong>BES</strong></td>
</tr>
<tr>
<td>“Superwoman” Stereotype</td>
<td>Binge Eating Symptom Composite</td>
</tr>
<tr>
<td><strong>Support Seeking and Utilization (SUP)</strong></td>
<td></td>
</tr>
<tr>
<td>SSB Total</td>
<td></td>
</tr>
<tr>
<td>WTSS Total</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 4

RESULTS

Bivariate Correlations

Bivariate correlations among the nine factors were calculated and are presented in the correlation matrix in Table 4. None of the correlations between SUP and the other factors were statistically significant; all other correlations among the factors were significant ($p$ values ranging from $< .05$ to $< .001$).

Bivariate correlations were also calculated between demographic variables (age, education level, employment status, and personal and household income), BMI, and each of the nine factors (see Table 5). Three variables exhibited significant relationships (or relationships approaching significance) with several of the factors (age: $r$ with STR = - .15, $p < .05$, SUP = -.21, $p < .01$, and BE = .15, $p < .05$; education: $r$ with STR = - .23, $p < .01$, EI/RD = -.20, $p < .01$, and BE = -.13, $p = .07$; and household income: $r$ with CAT = - .13, $p = .09$, STR = -.23, $p < .01$, EI/RD = -.20, $p < .01$, SIL = -.14, $p = .07$, and BE = - .13, $p = .09$). Age was significantly related to stress, one of the predictor variables, and to binge eating symptomatology, the outcome variable, and thus was designated as a covariate and controlled for in all subsequent regression analyses. Various researchers (e.g., Striegel-Moore & Smolak, 2000) have asserted the importance of controlling for
Table 4  *Correlation Matrix*

<table>
<thead>
<tr>
<th></th>
<th>CAT</th>
<th>STR</th>
<th>DISC</th>
<th>SBW</th>
<th>SUP</th>
<th>EI/RD</th>
<th>SIL</th>
<th>EPR</th>
<th>BE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STR</td>
<td>.31***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISC</td>
<td>.30***</td>
<td>.43***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBW</td>
<td>.38***</td>
<td>.34***</td>
<td>.36***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUP</td>
<td>.11 (172)</td>
<td>-.03 (170)</td>
<td>-.002 (163)</td>
<td></td>
<td></td>
<td>-14† (170)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EI/RD</td>
<td>.23** (187)</td>
<td>.52*** (185)</td>
<td>.39*** (177)</td>
<td>.41*** (185)</td>
<td></td>
<td>-.09 (166)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIL</td>
<td>.32*** (191)</td>
<td>.34*** (188)</td>
<td>.21** (179)</td>
<td>.41*** (188)</td>
<td>-.08 (166)</td>
<td>.50*** (180)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPR</td>
<td>.19* (182)</td>
<td>.18* (180)</td>
<td>.33*** (174)</td>
<td>.24** (180)</td>
<td>.03 (161)</td>
<td>.37*** (176)</td>
<td>.35*** (175)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BE</td>
<td>.18* (188)</td>
<td>.28*** (187)</td>
<td>.28*** (178)</td>
<td>.15* (185)</td>
<td>.04 (164)</td>
<td>.28*** (179)</td>
<td>.28*** (179)</td>
<td>.66*** (177)</td>
<td></td>
</tr>
</tbody>
</table>

*Note.  CAT = Criterion A Trauma; STR = Stress; DISC = Discriminatory Stress; SBW = Strong Black Woman Ideology; SUP = Support Seeking and Utilization; EI/RD = Emotional Inhibition and Regulation Difficulties; SIL = Self-Silencing; EPR = Eating for Psychological Reasons; BE = Binge Eating Symptomatology
* p < .05.  ** p < .01.  *** p < .001.  † p < .10.*
Table 5  Correlation Matrix – Demographic Variables and Factors

<table>
<thead>
<tr>
<th></th>
<th>CAT</th>
<th>STR</th>
<th>DISC</th>
<th>SBW</th>
<th>SUP</th>
<th>EI/RD</th>
<th>SIL</th>
<th>EPR</th>
<th>BE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.10</td>
<td>-15**</td>
<td>.02</td>
<td>.07</td>
<td>-21**</td>
<td>-00</td>
<td>-09</td>
<td>.11</td>
<td>.15**</td>
</tr>
<tr>
<td></td>
<td>(198)</td>
<td>(194)</td>
<td>(184)</td>
<td>(194)</td>
<td>(171)</td>
<td>(186)</td>
<td>(189)</td>
<td>(180)</td>
<td>(186)</td>
</tr>
<tr>
<td>Education Level</td>
<td>-.03</td>
<td>-23**</td>
<td>.01</td>
<td>-.03</td>
<td>.03</td>
<td>-20**</td>
<td>-10</td>
<td>-.05</td>
<td>-13†</td>
</tr>
<tr>
<td></td>
<td>(199)</td>
<td>(195)</td>
<td>(185)</td>
<td>(195)</td>
<td>(172)</td>
<td>(186)</td>
<td>(190)</td>
<td>(181)</td>
<td>(187)</td>
</tr>
<tr>
<td>Employment Status</td>
<td>-.01</td>
<td>-.04</td>
<td>.00</td>
<td>.12†</td>
<td>.03</td>
<td>.02</td>
<td>-16*</td>
<td>.03</td>
<td>-.01</td>
</tr>
<tr>
<td></td>
<td>(200)</td>
<td>(196)</td>
<td>(186)</td>
<td>(196)</td>
<td>(172)</td>
<td>(187)</td>
<td>(191)</td>
<td>(182)</td>
<td>(188)</td>
</tr>
<tr>
<td>Personal Income</td>
<td>-.05</td>
<td>-20**</td>
<td>.02</td>
<td>.10</td>
<td>-.10</td>
<td>-15*</td>
<td>-18*</td>
<td>.02</td>
<td>-.01</td>
</tr>
<tr>
<td></td>
<td>(175)</td>
<td>(173)</td>
<td>(163)</td>
<td>(172)</td>
<td>(152)</td>
<td>(165)</td>
<td>(167)</td>
<td>(162)</td>
<td>(166)</td>
</tr>
<tr>
<td>Household Income</td>
<td>-13†</td>
<td>-23**</td>
<td>-.05</td>
<td>-.03</td>
<td>.08</td>
<td>-20**</td>
<td>-14†</td>
<td>-.07</td>
<td>-13†</td>
</tr>
<tr>
<td></td>
<td>(181)</td>
<td>(179)</td>
<td>(169)</td>
<td>(178)</td>
<td>(158)</td>
<td>(170)</td>
<td>(173)</td>
<td>(168)</td>
<td>(172)</td>
</tr>
<tr>
<td>BMI</td>
<td>.05</td>
<td>.07</td>
<td>.05</td>
<td>.05</td>
<td>-.07</td>
<td>.02</td>
<td>.09</td>
<td>.20**</td>
<td>.33***</td>
</tr>
<tr>
<td></td>
<td>(200)</td>
<td>(196)</td>
<td>(186)</td>
<td>(196)</td>
<td>(172)</td>
<td>(187)</td>
<td>(191)</td>
<td>(182)</td>
<td>(188)</td>
</tr>
</tbody>
</table>

*Note.  CAT = Criterion A Trauma; STR = Stress; DISC = Discriminatory Stress; SBW = Strong Black Woman Ideology; SUP = Support Seeking and Utilization; EI/RD = Emotional Inhibition and Regulation Difficulties; SIL = Self-Silencing; EPR = Eating for Psychological Reasons; BE = Binge Eating Symptomatology; BMI = Body Mass Index

* p < .05.  ** p < .01.  *** p < .001.  † p < .10.
socioeconomic status (SES), particularly when conducting research with participants of color. In light of this argument, as well as the fact that education and household income exhibited significant relationships with one or more predictor variables (e.g., stress, emotional inhibition and regulation difficulties) and relationships with binge eating that approached statistical significance, these two variables were also selected as covariates, thus serving as a proxy for SES and enabling examination of the hypothesized relationships independent of SES. Because BMI was not significantly related to any of the predictor variables (trauma, stress, or discriminatory stress), the moderator variable (SBW ideology), or three of the four mediator variables (support seeking and utilization, emotional inhibition/regulation difficulties, or self-silencing), this variable was not selected as a covariate.

Regression Analyses

Hypothesis 1. Hierarchical multiple regression analyses were conducted to test whether trauma, stress, and discriminatory stress were related to binge eating after controlling for the influence of demographic variables (see Table 6). Demographic variables (age, education, and household income) were entered first as covariates, followed by the relevant predictor variable. As hypothesized, Criterion A trauma ($\beta = .19, t = 2.45, p < .05$), stress ($\beta = .33, t = 4.38, p < .001$), and discriminatory stress ($\beta = .25, t = 3.24, p < .01$) were each significant predictors of binge eating symptomatology after controlling for demographic factors. When these three variables were entered simultaneously (along with demographic covariates; see Table 7), only stress
Table 6  *Hierarchical Regressions for Hypothesis 1*

**Criterion A Trauma**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.05</td>
<td>.05</td>
<td>.01</td>
<td>.01</td>
<td>.14†</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td>-08</td>
<td>.05</td>
<td>-.13</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
<td>-01</td>
<td>.04</td>
<td>-.01</td>
</tr>
<tr>
<td>Criterion A Trauma</td>
<td>.08</td>
<td>.03</td>
<td>.19</td>
<td>.08</td>
<td>.19*</td>
</tr>
</tbody>
</table>

**Stress**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.05</td>
<td>.05</td>
<td>.02</td>
<td>.01</td>
<td>.21**</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td>-05</td>
<td>.05</td>
<td>-.09</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
<td>.01</td>
<td>.03</td>
<td>.02</td>
</tr>
<tr>
<td>Stress</td>
<td>.15</td>
<td>.10</td>
<td>.3</td>
<td>.07</td>
<td>.33***</td>
</tr>
</tbody>
</table>

**Discriminatory Stress**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.04</td>
<td>.04</td>
<td>.01</td>
<td>.01</td>
<td>.17*</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td>-.07</td>
<td>.06</td>
<td>-.11</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
<td>-.003</td>
<td>.04</td>
<td>-.01</td>
</tr>
<tr>
<td>Discriminatory Stress</td>
<td>.10</td>
<td>.06</td>
<td>.24</td>
<td>.08</td>
<td>.25**</td>
</tr>
</tbody>
</table>

* $p < .05$.  ** $p < .01$.  *** $p < .001$.  † $p < .10$.  

---

---

---

---

---
Table 7  Hierarchical Regressions for Hypothesis 1 (All Variables Entered Simultaneously)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.04</td>
<td>.04</td>
<td>.02</td>
<td>.01</td>
<td>.21**</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td>-.05</td>
<td>.05</td>
<td>.05</td>
<td>-.07</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td>.03</td>
<td>.04</td>
<td>.04</td>
<td>.07</td>
</tr>
<tr>
<td>Criterion A Trauma</td>
<td>.19</td>
<td>.15</td>
<td>.14</td>
<td>.08</td>
<td>.13†</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td>.28</td>
<td>.09</td>
<td>.09</td>
<td>.29**</td>
</tr>
<tr>
<td>Discriminatory Stress</td>
<td></td>
<td>.06</td>
<td>.09</td>
<td>.09</td>
<td>.07</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. † $p < .10$. 
significantly predicted binge eating symptomatology ($\beta = .29$, $t = 3.26$, $p < .001$).

Hypothesis 2. A hierarchical multiple regression analysis was conducted to determine if SBW ideology moderated the relationship between trauma and binge eating symptomatology (see Table 8). According to Baron and Kenny (1986), moderation is indicated when the interaction term between the independent variable and the moderator accounts for a significant proportion of the variance beyond that accounted for the main effects of the independent variable and the moderator. In the present regression analysis, demographic variables were entered first as covariates, followed by trauma, stress, and discriminatory stress; SBW ideology; and the trauma x SBW ideology interaction. Neither the main effects for trauma ($\beta = .12$, $t = 1.39$, $p > .10$) nor SBW ideology ($\beta = .01$, $t = .16$, $p > .10$) were significant, while the interaction term ($\beta = .15$, $t = 1.99$, $p < .05$) was statistically significant. The model accounted for 20.2% of the variance in binge eating symptomatology.

Because the trauma x SBW ideology interaction term was statistically significant, a decomposition analysis (Jaccard, Wan, & Turrisi, 1990) was conducted to determine whether the slope of binge eating symptomatology was significantly different from zero for women endorsing high and low levels of SBW ideology (see Figure 2). The slope of binge eating symptomatology was significantly different from zero for women high on SBW ideology (slope = .28, $t = 2.55$, $p < .05$) but not for women low on SBW ideology (slope = -.04, $t = -.34$, $p > .10$). These results suggest that SBW ideology does moderate the relationship between trauma and binge eating symptomatology. Specifically, women high in SBW ideology reported greater binge eating symptomatology with increasing
Table 8  *Summary of Hierarchical Regression Analyses for Hypothesis 2*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trauma</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td>.04</td>
<td>.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criterion A Trauma</td>
<td>.18</td>
<td>.14</td>
<td>.12</td>
<td>.09</td>
<td>.12</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discriminatory Stress</td>
<td>.06</td>
<td>.09</td>
<td>.06</td>
<td></td>
<td>.06</td>
</tr>
<tr>
<td>SBW Ideology</td>
<td>.18</td>
<td>.001</td>
<td>.01</td>
<td>.09</td>
<td>.01</td>
</tr>
<tr>
<td>Interaction Term</td>
<td>.20</td>
<td>.02</td>
<td>.16</td>
<td>.08</td>
<td>.15*</td>
</tr>
<tr>
<td><strong>Stress</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td>.04</td>
<td>.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criterion A Trauma</td>
<td>.18</td>
<td>.14</td>
<td>.13</td>
<td>.09</td>
<td>.13</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discriminatory Stress</td>
<td>.05</td>
<td>.09</td>
<td>.05</td>
<td></td>
<td>.05</td>
</tr>
<tr>
<td>SBW Ideology</td>
<td>.18</td>
<td>.001</td>
<td>.03</td>
<td>.09</td>
<td>.03</td>
</tr>
<tr>
<td>Interaction Term</td>
<td>.18</td>
<td>.00</td>
<td>.01</td>
<td>.07</td>
<td>.01</td>
</tr>
<tr>
<td><strong>Discriminatory Stress</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td>.04</td>
<td>.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criterion A Trauma</td>
<td>.18</td>
<td>.14</td>
<td>.13</td>
<td>.09</td>
<td>.13</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discriminatory Stress</td>
<td>.05</td>
<td>.09</td>
<td>.05</td>
<td></td>
<td>.05</td>
</tr>
<tr>
<td>SBW Ideology</td>
<td>.18</td>
<td>.001</td>
<td>.03</td>
<td>.09</td>
<td>.03</td>
</tr>
<tr>
<td>Interaction Term</td>
<td>.18</td>
<td>.00</td>
<td>.002</td>
<td>.07</td>
<td>.002</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. 
Figure 2  SBW Ideology as a Moderator of the Relationship Between Criterion A Trauma and Binge Eating Symptomatology
exposure to and distress associated with Criterion A trauma. In contrast, binge eating symptomatology among women low in SBW ideology did not appear to increase significantly with increased Criterion A trauma exposure and distress.

A comparable regression analysis was conducted to test whether SBW ideology moderated the relationship between stress and binge eating symptomatology (see Table 8). The main effect for stress was significant ($\beta = .29, t = 3.11, p < .01$), while neither the main effect for SBW ideology ($\beta = .03, t = .33, p > .10$) nor the interaction term ($\beta = .01, t = .07, p > .10$) were significant. The model accounted for 18.1% of the variance in binge eating symptomatology.

Finally, a hierarchical multiple regression was conducted to determine if SBW ideology moderated the relationship between discriminatory stress and binge eating symptomatology (see Table 8). Neither the main effect for discriminatory stress ($\beta = .05, t = .52, p > .10$) nor for SBW ideology ($\beta = .03, t = .34, p > .10$) were significant; further, the interaction term was also not significant ($\beta = .002, t = .02, p > .10$). The model accounted for 18.1% of the variance in binge eating symptomatology.

**Hypothesis 3.** Kenny, Kashy, and Bolger’s (1998) guidelines for testing mediational hypotheses were utilized in order to test whether the relationship between SBW ideology and binge eating symptomatology was mediated by support-seeking and utilization, emotional inhibition and regulation difficulties, and self-silencing (see Table 9). According to Kenny and his colleagues, the following steps are needed to establish mediation: 1) the independent variable significantly predicts the dependent variable; 2)
<table>
<thead>
<tr>
<th>Mediator</th>
<th>SBW Ideology to Binge Eating</th>
<th>SBW Ideology to Mediator</th>
<th>Mediator to Binge Eating (SBW Ideology Included)</th>
<th>SBW Ideology to Binge Eating (Mediator Included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support-Seeking and Utilization</td>
<td>.15 (.08)*</td>
<td>-.08 (.08)</td>
<td>.10 (.08)</td>
<td>.15 (.08)†</td>
</tr>
<tr>
<td>Emotional Inhibition and Regulation Difficulties</td>
<td>.15 (.08)*</td>
<td>.39 (.07)***</td>
<td>.25 (.09)**</td>
<td>.04 (.08)</td>
</tr>
<tr>
<td>Self-Silencing</td>
<td>.15 (.08)*</td>
<td>.41 (.07)***</td>
<td>.27 (.08)**</td>
<td>.05 (.08)</td>
</tr>
</tbody>
</table>

*Note.* Demographic variables were entered first as covariates in all analyses.

* p < .05. ** p < .01. *** p < .001. † p < .10.
the independent variable significantly predicts the mediator; 3) the mediator significantly predicts the dependent variable while controlling for the independent variable; and 4) when the independent variable and the mediator are entered simultaneously, the relationship between the independent variable and dependent variable is significantly reduced.\(^1\) SBW ideology significantly predicted binge eating symptomatology \((\beta = .15, t = 2.03, p < .05)\) after controlling for demographic variables. However, SBW ideology did not significantly predict support seeking and utilization \((\beta = -.08, t = -.96, p > .10)\); thus, further mediational hypotheses were not tested.

In contrast, SBW ideology did predict emotional inhibition and regulation difficulties \((\beta = .39, t = 5.56, p < .001)\), and emotional inhibition and regulation difficulties were significantly related to binge eating symptomatology \((\beta = .25, t = 2.96, p < .01)\). When SBW ideology and emotional inhibition and regulation difficulties were entered simultaneously, the relationship between SBW ideology and binge eating symptomatology was reduced to nonsignificance \((\beta = .04, t = .42, p > .10)\). A Sobel test was conducted to determine whether the indirect effect of SBW ideology on binge eating symptomatology via emotional inhibition and regulation difficulties was significantly different from zero \((\text{test statistic} = 2.61, p < .01)\). These results are consistent with full mediation, such that SBW ideology influenced binge eating symptomatology through its effects on emotional inhibition and regulation difficulties (after controlling for demographic variables).

\(^1\) If the relationship between the independent variable and the dependent variable is reduced to nonsignificance, full mediation has occurred; if the relationship is significantly reduced but still remains statistically significant, partial mediation has occurred.
Similarly, SBW ideology significantly predicted self-silencing ($\beta = .41, t = 5.80, p < .001$), and self-silencing was significantly related to binge eating symptomatology ($\beta = .27, t = 3.18, p < .01$). When SBW ideology and self-silencing were entered simultaneously, the relationship between SBW ideology and binge eating symptomatology was reduced to nonsignificance ($\beta = .05, t = .56, p > .10$). A Sobel test was conducted to determine whether the indirect effect of SBW ideology on binge eating symptomatology via self-silencing was significantly different from zero (test statistic = 2.79, $p < .01$). These results are consistent with full mediation, such that SBW ideology influenced binge eating symptomatology through its effects on self-silencing (after controlling for demographic variables).

**Hypothesis 4.** To test whether eating for psychological reasons mediated the relationships between SBW ideology, support seeking and utilization, emotional inhibition and regulation difficulties, self-silencing, and binge eating symptomatology, a series of hierarchical regressions were conducted (see Table 10). Demographic variables were entered first into all regressions as a covariate.

SBW ideology significantly predicted binge eating symptomatology ($\beta = .15, t = 2.03, p < .05$) and eating for psychological reasons ($\beta = .29, t = 3.78, p < .001$), and eating for psychological reasons was significantly related to binge eating symptomatology ($\beta = .67, t = 10.93, p < .001$). When SBW ideology and eating for psychological reasons were entered simultaneously, the relationship between SBW ideology and binge eating symptomatology was reduced to nonsignificance ($\beta = -.02, t = -0.33, p > .10$). A Sobel test was conducted to determine whether the indirect effect of
Table 10  *Standardized Coefficients (and Standard Errors) of Paths in Analyses of the Mediating Effects of Eating for Psychological Reasons*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable to Binge Eating</th>
<th>Variable to Eating for Psychological Reasons</th>
<th>Eating for Psychological Reasons to Binge Eating (Variable Included)</th>
<th>Variable to Binge Eating (Eating for Psychological Reasons Included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBW Ideology</td>
<td>.15 (.08)*</td>
<td>.29 (.07)**</td>
<td>.67 (.06)**</td>
<td>-.02 (.06)</td>
</tr>
<tr>
<td>Support-Seeking and Utilization</td>
<td>.09 (.08)</td>
<td>.03 (.08)</td>
<td>.66 (.06)**</td>
<td>.06 (.06)</td>
</tr>
<tr>
<td>Emotional Inhibition and Regulation Difficulties</td>
<td>.27 (.08)**</td>
<td>.43 (.07)**</td>
<td>.67 (.07)**</td>
<td>-.004 (.07)</td>
</tr>
<tr>
<td>Self-Silencing</td>
<td>.29 (.08)**</td>
<td>.38 (.07)**</td>
<td>.64 (.07)**</td>
<td>.06 (.06)</td>
</tr>
</tbody>
</table>

*Note.* Demographic variables were entered first as covariates in all analyses.

* p < .05.  ** p < .01.  *** p < .001.
SBW ideology on binge eating symptomatology via eating for psychological reasons was significantly different from zero (test statistic = 3.59, $p < .001$). These results are consistent with full mediation, such that SBW ideology influenced binge eating symptomatology through its effects on eating for psychological reasons (after controlling for demographic variables).

Support-seeking and utilization did not significantly predict binge eating symptomatology ($\beta = .09, t = 1.08, p > .10$) or eating for psychological reasons ($\beta = .03, t = 0.40, p > .10$); therefore, further mediational hypotheses were not tested. In contrast, emotional inhibition and regulation difficulties significantly predicted both binge eating symptomatology ($\beta = .27, t = 3.46, p < .01$) and eating for psychological reasons ($\beta = .43, t = 5.70, p < .001$). When emotional inhibition and regulation difficulties and eating for psychological reasons were entered simultaneously, the relationship between emotional inhibition and regulation difficulties and binge eating symptomatology was reduced to nonsignificance ($\beta = -.004, t = -0.06, p > .10$). A Sobel test was conducted to determine whether the indirect effect of emotional inhibition and regulation difficulties on binge eating symptomatology via eating for psychological reasons was significantly different from zero (test statistic = 4.99, $p < .001$). These results are consistent with full mediation, such that emotional inhibition and regulation difficulties influenced binge eating symptomatology through their effects on eating for psychological reasons (after controlling for demographic variables).

Finally, self-silencing significantly predicted both binge eating symptomatology ($\beta = .29, t = 3.82, p < .001$) and eating for psychological reasons ($\beta = .38, t = 5.03, p < .001$).
When self-silencing and eating for psychological reasons were entered simultaneously, the relationship between self-silencing and binge eating symptomatology was reduced to nonsignificance ($\beta = .06, t = .98, p > .10$). A Sobel test was conducted to determine whether the indirect effect of self-silencing on binge eating symptomatology via eating for psychological reasons was significantly different from zero (test statistic = 4.48, $p < .001$). These results are consistent with full mediation, such that self-silencing influenced binge eating symptomatology through its effects on eating for psychological reasons (after controlling for demographic variables).

**Structural Path Analyses**

In order to test the proposed model, a structural path analysis was conducted. This technique, a specific type of structural equation modeling, allows for a comprehensive test of hypotheses about the associations among variables by simultaneously evaluating the relationships between the constructs and error to achieve the best fit between the model and the actual data. Model fit is evaluated by several fit indices; acceptable fit is indicated by a non-significant chi-square, a $\chi^2$/df value of less than 3, a Comparative Fit Index (CFI) of .95 or greater, and a root mean squared error of approximation of approximately .06 or a standardized root mean squared residual (SRMR) of approximately .08. These fit indices and accompanying recommended values have been shown to minimize both Type I and Type II error rates (e.g., Hu & Bentler, 1999).
Before conducting the analysis, one preliminary change was made to the originally hypothesized model. For several reasons, including the absence of significant relationships between the SUP variable and all other variables and the large amounts of missing data on this variable, the SUP variable was omitted from the model in the subsequent analyses. This modified model (see Figure 3) was initially tested on the full sample. Model fit was achieved in twelve iterations with a constant alpha step of 1.0 and a steady decrease in the function value. Fit indices suggested a poor fit to the data [Satorra-Bentler $\chi^2(12) = 104.71, p < .001; \chi^2/df = 8.73; CFI = .58; \text{SRMR} = .17; \text{RMSEA} = .23$ (90% confidence interval = $.19 – .27)].

Consistent with recommendations of Ullman (2001) and others, model modification was undertaken to improve fit and allow for hypothesis testing. Using a series of nested models (i.e., where the tested models are subsets of each other), modifications were made sequentially on the basis of theoretical rationale and recommendations from the Lagrange Multiplier (LM) and Wald tests. The fit improvement with each subsequent modification was assessed with the chi-square difference test, where the chi-square value for the larger model was subtracted from the value for the smaller nested model; modifications were considered to significantly improve the model if they resulted in a statistically significant decrease in the chi-square value (Tabachnick & Fidell, 2006).

---

2 The sample lacked a sufficient number of participants to conduct structural equation modeling using latent variables and indicators of those variables. Instead, structural path analyses were conducted using observed variables (the factor scores created earlier via factor analysis).
Satorra-Bentler $\chi^2$ (12) = 104.71***
$\chi^2$/df = 8.73
CFI = .58
SRMR = .17
RMSEA = .23 (90% CI = .19-.27)

Solid line = Significant path
Dashed line = Nonsignificant path
Dotted line = Error

CAT = Criterion A Trauma
STR = Stress
DISC = Discriminatory Stress
EI/RD = Emotional Inhibition/Regulation Difficulties
SIL = Self-Silencing
EPR = Eating for Psychological Reasons
BE = Binge Eating

Figure 3  *Originally Hypothesized Model – Full Sample*
Table 11  *Comparison of Nested Models for the Full Sample (N = 193)*

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Iterations</th>
<th>Satorra-Bentler $\chi^2$ (df)</th>
<th>$\chi^2$/df</th>
<th>CFI</th>
<th>RMSEA (90%CI)</th>
<th>$\chi^2$ Difference Test</th>
<th>AIC</th>
<th>CAIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypothesized Model</td>
<td>12</td>
<td>104.71*** (12)</td>
<td>8.73</td>
<td>.58</td>
<td>.23 (.19-.27)</td>
<td></td>
<td>80.71</td>
<td>32.58</td>
</tr>
<tr>
<td>2</td>
<td>Added EI/RD-SIL error correlation</td>
<td>12</td>
<td>50.53*** (11)</td>
<td>4.59</td>
<td>.82</td>
<td>.16 (.11-.20)</td>
<td>M1 – M2 = 54.18***</td>
<td>28.53</td>
<td>-15.59</td>
</tr>
<tr>
<td>3</td>
<td>Added DISC-STR correlation</td>
<td>7</td>
<td>27.45** (10)</td>
<td>2.75</td>
<td>.92</td>
<td>.11 (.06-.16)</td>
<td>M2 – M3 = 23.08***</td>
<td>7.45</td>
<td>-32.66</td>
</tr>
<tr>
<td>4</td>
<td>Added BE-STR</td>
<td>7</td>
<td>17.32* (9)</td>
<td>1.92</td>
<td>.96</td>
<td>.08 (.01-.13)</td>
<td>M3 – M4 = 10.13***</td>
<td>-0.68</td>
<td>-36.78</td>
</tr>
<tr>
<td>5</td>
<td>Added STR-CAT correlation</td>
<td>7</td>
<td>13.01 (8)</td>
<td>1.63</td>
<td>.98</td>
<td>.07 (0.00-.07)</td>
<td>M4 – M5 = 4.31*</td>
<td>-2.99</td>
<td>-35.07</td>
</tr>
<tr>
<td>6</td>
<td>Added DISC-CAT correlation</td>
<td>7</td>
<td>5.73 (7)</td>
<td>0.82</td>
<td>1.0</td>
<td>0 (0.00-.10)</td>
<td>M5 – M6 = 7.28**</td>
<td>-8.27</td>
<td>-36.34</td>
</tr>
<tr>
<td>7</td>
<td>Deleted SIL-DISC</td>
<td>7</td>
<td>5.80 (8)</td>
<td>0.73</td>
<td>1.0</td>
<td>0 (0.00-.08)</td>
<td>M6 – M7 = -0.07</td>
<td>-10.20</td>
<td>-42.29</td>
</tr>
<tr>
<td>8</td>
<td>Deleted EI/RD-CAT</td>
<td>7</td>
<td>6.66 (9)</td>
<td>0.74</td>
<td>1.0</td>
<td>0 (0.00-.07)</td>
<td>M7 – M8 = -0.86</td>
<td>-11.34</td>
<td>-47.43</td>
</tr>
</tbody>
</table>

*Note.* CAT = Criterion A Trauma; STR = Stress; DISC = Discriminatory Stress; SBW = Strong Black Woman Ideology; SUP = Support Seeking and Utilization; EI/RD = Emotional Inhibition and Regulation Difficulties; SIL = Self-Silencing; EPR = Eating for Psychological Reasons; BE = Binge Eating Symptomatology

* $p < .05$. ** $p < .01$. *** $p < .001$. 
The first modification to the model was correlating the error terms for the EI/RD and SIL variables (see Table 11, Model 2). Both of these variables are proposed mediators, and thus would be expected to be correlated (and in fact, were significantly correlated in the present sample \( r = .59, p < .001 \)). Because EI/RD and SIL are endogenous variables, the respective error terms rather than the variables themselves were correlated. This modification resulted in a significant decrease in the chi-square statistic and thus a significant improvement in the model fit \( \chi^2(1) = 54.18, p < .001 \).

After adding this correlation, the fit indices also evidenced improvement [Satorra-Bentler \( \chi^2(11) = 50.53, p < .001; \chi^2/df = 4.59; \text{CFI} = .82; \text{SRMR} = .14; \text{RMSEA} = .16 \) (90% confidence interval = .11 – .20); see Figure 3], though still suggested a poor fit to the data.

Subsequent modifications to the model consisted of adding correlations (DISC and STR, STR and CAT, and DISC and CAT) or paths (STR to BE) suggested by the LM test; each of these modifications yielded significant decreases in the chi-square statistic and thus significant improvements in model fit (\( \chi^2 \) statistics ranging from 4.31 to 23.08, \( p \) values ranging from < .05 to < .001; see Table 11, Models 3-6). Further, both the AIC (values ranging from -8.27 to 7.45) and CAIC (values ranging from -32.66 to -36.78) indicated better fitting, more parsimonious models after each modification, and the fit indices improved considerably.

Next, the paths between SIL and DISC (Model 7) and between EI/RD and CAT (Model 8) were deleted based on the recommendations of the Wald test. However, results of chi-square difference tests were not statistically significant \( \chi^2(1) = -.07 \) and -
Thus, the final model used in remaining analyses is the model from step 6, the originally hypothesized model with the following added paths: EI/RD-SIL error correlation, DISC-STR correlation, BE-STR path, STR-CAT correlation, and DISC-CAT correlation (see Figure 4). For the full sample, model fit was achieved in seven iterations with a constant alpha step of 1.0 and a steady decrease in the function value. Fit indices suggested an excellent fit to the data [Satorra-Bentler $\chi^2(7) = 5.73, p > .10$; $\chi^2/df = 0.82$; CFI = 1.0; SRMR = .03; RMSEA = 0 (90% confidence interval = .00 – .09); see Table 8]. Almost all of the direct effects were significant; the two exceptions were the paths from CAT to EI/RD and from DISC to SIL. These findings suggest that EI/RD and SIL may play an important mediating role and that, specifically, the relationship between CAT and EPR is mediated by SIL; the relationship between STR and EPR is mediated by both EI/RD and SIL; and the relationship between DISC and EPR is mediated by EI/RD.

To confirm these mediational hypotheses, four sets of post hoc multiple regression analyses were conducted (see Figure 5). Demographic variables were entered first into all regressions as a covariate. CAT significantly predicted eating for psychological reasons ($\beta = .24, t = 3.03, p < .01$) and self-silencing ($\beta = .33, t = 4.50, p < .001$), and self-silencing was significantly related to eating for psychological reasons ($\beta = .34, t = 4.28, p < .001$). When CAT and self-silencing were entered simultaneously, the relationship between CAT and eating for psychological reasons was reduced to nonsignificance ($\beta = .13, t = 1.67, p < .10$). A Sobel test was conducted to determine
Satorra-Bentler $\chi^2 (7) = 5.73$
$\chi^2$/df = .82
CFI = 1.0
SRMR = .03
RMSEA = 0 (90% CI = .00-.09)

Solid line = Significant path
Dashed line = Nonsignificant path
Dotted line = Error

CAT = Criterion A Trauma
STR = Stress
DISC = Discriminatory Stress
EI/RD = Emotional Inhibition/Regulation Difficulties
SIL = Self-Silencing
EPR = Eating for Psychological Reasons
BE = Binge Eating

Figure 4 Final Model -- Full Sample
Figure 5  Post Hoc Mediational Hypotheses
Figure 5 Post Hoc Mediational Hypotheses (Continued)
whether the indirect effect of CAT on eating for psychological reasons via self-silencing was significantly different from zero (test statistic = 3.10, \( p < .01 \)). These results are consistent with full mediation, such that Criterion A Trauma influenced eating for psychological reasons through its effects on self-silencing (after controlling for demographic variables).

STR significantly predicted eating for psychological reasons (\( \beta = .53, t = 7.81, p < .001 \)) and emotional inhibition and regulation difficulties (\( \beta = .26, t = 3.19, p < .01 \)), and emotional inhibition and regulation difficulties were significantly related to eating for psychological reasons (\( \beta = .42, t = 4.68, p < .001 \)). When STR and emotional inhibition/regulation difficulties were entered simultaneously, the relationship between STR and eating for psychological reasons was reduced to nonsignificance (\( \beta = .02, t = .23, p > .10 \)). A Sobel test was conducted to determine whether the indirect effect of STR on eating for psychological reasons via emotional inhibition and regulation difficulties was significantly different from zero (test statistic = 2.64, \( p < .01 \)). Similarly, STR significantly predicted self-silencing (\( \beta = .33, t = 4.27, p < .001 \)), and self-silencing was significantly related to eating for psychological reasons (\( \beta = .33, t = 4.15, p < .001 \)). When STR and self-silencing were entered simultaneously, the relationship between STR and eating for psychological reasons was reduced to nonsignificance (\( \beta = .14, t = 1.63, p > .10 \)). A Sobel test was conducted to determine whether the indirect effect of STR on eating for psychological reasons via self-silencing was significantly different from zero (test statistic = 2.98, \( p < .01 \)). These results are consistent with full mediation, such that stress influenced eating for psychological reasons through its effects on emotional
inhibition and regulation difficulties and self-silencing (after controlling for demographic variables).

Finally, DISC significantly predicted eating for psychological reasons ($\beta = .33$, $t = 4.33$, $p < .001$) and emotional inhibition and regulation difficulties ($\beta = .36$, $t = 5.00$, $p < .001$), and emotional inhibition and regulation difficulties were significantly related to eating for psychological reasons ($\beta = .36$, $t = 4.37$, $p < .001$). When DISC and emotional inhibition/regulation difficulties were entered simultaneously, the relationship between DISC and eating for psychological reasons was reduced to nonsignificance ($\beta = .14$, $t = 1.77$, $p < .10$). A Sobel test was conducted to determine whether the indirect effect of DISC on eating for psychological reasons via emotional inhibition and regulation difficulties was significantly different from zero (test statistic = 3.28, $p < .01$). These results are consistent with full mediation, such that discriminatory stress influenced eating for psychological reasons through its effects on emotional inhibition and regulation difficulties (after controlling for demographic variables).

**Moderation.** This model was then tested separately for the high SBW participants ($n = 62$) and for the low SBW participants ($n = 65$), designated as the upper and lower tertiles of the distribution (see Table 12). For the high SBW participants, model fit was achieved in seven iterations with a constant alpha step of 1.0 and a steady decrease in the function value. Fit indices suggested an acceptable fit to the data [Satorra-Bentler $\chi^2(7) = 14.13$, $p = .049$; $\chi^2/df = 2.02$; CFI = .90; SRMR = .08, RMSEA = .14 (90% confidence interval = .01 – .25); see Figure 6]. Three direct paths were significant: from STR to EI/RD, from STR to SIL, and from EPR to BE. For the low SBW participants, model fit was achieved
Table 12  Comparison of the Final Model for the Full Sample and High and Low SBW Participants

<table>
<thead>
<tr>
<th>Description</th>
<th>Iterations</th>
<th>Satorra-Bentler $\chi^2$ (df)</th>
<th>$\chi^2$/df</th>
<th>CFI</th>
<th>RMSEA (90% CI)</th>
<th>AIC</th>
<th>CAIC</th>
<th>Significant Paths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Sample (N = 193)</td>
<td>7</td>
<td>5.73 (7)</td>
<td>0.82</td>
<td>1.0</td>
<td>0 (.00-.10)</td>
<td>-8.27</td>
<td>-36.34</td>
<td>STR-EI/RD, DISC-EI/RD, CAT-SIL, STR-SIL, EI/RD-FXN, SIL-FXN, FXN-BE, STR-BE</td>
</tr>
<tr>
<td>High SBW Participants (n = 62)</td>
<td>7</td>
<td>14.13* (7)</td>
<td>2.02</td>
<td>.90</td>
<td>.14 (.01-.25)</td>
<td>0.13</td>
<td>-20.39</td>
<td>STR-EI/RD, STR-SIL, FXN-BE</td>
</tr>
<tr>
<td>Low SBW Participants (n = 65)</td>
<td>7</td>
<td>6.61 (7)</td>
<td>0.94</td>
<td>1.0</td>
<td>0 (.00-.17)</td>
<td>-7.39</td>
<td>-27.63</td>
<td>FXN-BE</td>
</tr>
</tbody>
</table>

Note. CAT = Criterion A Trauma; STR = Stress; DISC = Discriminatory Stress; SBW = Strong Black Woman Ideology; SUP = Support Seeking and Utilization; EI/RD = Emotional Inhibition and Regulation Difficulties; SIL = Self-Silencing; EPR = Eating for Psychological Reasons; BE = Binge Eating Symptomatology

* $p < .05$. ** $p < .01$. *** $p < .001$. 
Satorra-Bentler $\chi^2$ (7) = 14.13
$\chi^2$/df = 2.02
CFI = .90
SRMR = .08
RMSEA = .14 (90% CI = .01-.25)

Solid line = Significant path
Dashed line = Nonsignificant path
Dotted line = Error

Figure 6 Final Model – High SBW Participants
in seven iterations with a constant alpha step of 1.0 and a steady decrease in the function value. Fit indices suggested an excellent fit to the data [Satorra-Bentler $\chi^2(7) = 6.61, p > .10; \chi^2/df = 0.94; \text{CFI} = 1.0; \text{SRMR} = .07; \text{RMSEA} = 0$ (90% confidence interval = .00 – .17); see Figure 7]. Only one direct path was significant, that from EPR to BE.

The fit of the final model differed for the participants endorsing high and low levels of SBW ideology, with Satorra-Bentler chi-square values of 14.13 and 6.61, respectively. In addition, the size and significance of the unstandardized path coefficients in the final model differed notably among the groups (see Table 13). Among the high SBW participants, three path coefficients (STR-EI/RD, STR-SIL, and EPR-BE) were significant at the .05 level or greater, while among the low SBW participants, only the EPR-BE path coefficient was statistically significant. Similarly, among the high SBW group, three correlations (CAT-STR, STR-DISC, and EI/RD-SIL) were significant, while among the low SBW group, only the STR-DISC and EI/RD-SIL correlations were significant.

However, given that sample size strongly influences the significance of path coefficients and correlations and that the high and low SBW groups were comprised of many fewer participants (62 and 65) than the full sample (193), it may be more instructive to examine the size of the unstandardized path coefficients for the high and low SBW participants. In comparing the path coefficients for the two groups, several notable differences emerged. For the high SBW participants, the paths from STR to EI/RD and STR to SIL were 95.24% and 620% larger than among the low SBW participants. In contrast, the paths from CAT-SIL, DISC-EI/RD, and DISC-SIL were
Figure 7  Final Model – Low SBW Participants
Table 13 Unstandardized Path Coefficients for the Full Sample and High and Low SBW Participants

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>0.23*</td>
<td>0.34*</td>
<td>0.19*</td>
<td>0.07</td>
<td>0.38*</td>
<td>0.19*</td>
<td>0.26*</td>
<td>0.30*</td>
<td>-0.00</td>
<td>0.39*</td>
<td>0.20*</td>
<td>0.20*</td>
<td>0.57*</td>
<td>0.20*</td>
</tr>
<tr>
<td>High</td>
<td>0.32*</td>
<td>0.26*</td>
<td>0.03</td>
<td>-0.02</td>
<td>0.41*</td>
<td>-0.07</td>
<td>0.16</td>
<td>0.36*</td>
<td>-0.26</td>
<td>0.32*</td>
<td>0.16</td>
<td>0.29</td>
<td>0.59*</td>
<td>0.02</td>
</tr>
<tr>
<td>Low</td>
<td>-0.04</td>
<td>0.23*</td>
<td>0.09</td>
<td>0.07</td>
<td>0.21</td>
<td>0.22</td>
<td>0.27</td>
<td>0.05</td>
<td>0.19</td>
<td>0.44*</td>
<td>0.11</td>
<td>0.18</td>
<td>0.45*</td>
<td>0.16</td>
</tr>
<tr>
<td>% Dif</td>
<td>700</td>
<td>13.04</td>
<td>200</td>
<td>250</td>
<td>95.24</td>
<td>214.29</td>
<td>68.75</td>
<td>620</td>
<td>36.84</td>
<td>45.45</td>
<td>61.11</td>
<td>31.11</td>
<td>700</td>
<td></td>
</tr>
</tbody>
</table>

*Note. CAT = Criterion A Trauma; STR = Stress; DISC = Discriminatory Stress; SBW = Strong Black Woman Ideology; SUP = Support Seeking and Utilization; EI/RD = Emotional Inhibition and Regulation Difficulties; SIL = Self-Silencing; EPR = Eating for Psychological Reasons; BE = Binge Eating Symptomatology; % Dif = Percentage Difference

* *p < .05. ** p < .01. *** p < .001.
68.75%, 214.29%, and 36.84% larger, respectively, among the low SBW participants relative to the high SBW participants. Further, the direction of the relationships between DISC and EI/RD and between DISC and SIL was positive for the low SBW participants and negative for the high SBW participants. In addition, the correlation between CAT and STR was 700% stronger and the path from SIL to EPR was 61.11% stronger among high SBW participants. Finally, the path from STR to BE was 700% stronger among low SBW participants.

In summary, among the high SBW participants, STR exhibited strong positive relationships with EI/RD and SIL and influenced BE through its effects on these constructs. In contrast, among the low SBW participants, DISC exhibited stronger relationships with EI/RD and SIL, while STR had a direct effect on BE. Further, the directionality of the relationships among DISC and EI/RD and DISC and SIL differed; these relationships were negative for the high SBW and positive for the low SBW participants.
CHAPTER 5

DISCUSSION

The principal goal of the present study was to test a culturally specific model of binge eating in order to elucidate factors influencing this behavior among African American women. As predicted, trauma, stress, and discriminatory stress were each significantly related to binge eating symptomatology; further, these relationships remained after controlling for demographic variables. These findings replicate and further extend previous research, as they are based on a larger, more heterogeneous sample of African American women than prior studies (e.g., Harrington et al., 2006) and represent the effects of traumatic, stressful, and discriminatory experiences beyond demographic factors such as socioeconomic status that may be key confounds. In addition, the present findings provide critical information about the mechanisms by which trauma, stress, discriminatory stress might be related to binge eating, as well as the conditions under which these relationships are likely to occur. Four other variables emerged as salient constructs influencing binge eating symptomatology: SBW ideology, which served as a moderator; and emotional inhibition and regulation difficulties, self-silencing, and eating for psychological reasons, which served as mediators.
**SBW Ideology as a Moderator**

Based on the present findings, SBW ideology appears to play a pivotal role in African American women’s binge eating. Results of the multiple regression analyses indicated that in addition to emerging as a significant predictor of binge eating, SBW ideology also moderated the relationship between trauma and binge eating such that women who strongly endorsed the SBW image reported greater binge eating symptomatology with increasing trauma exposure and distress, while binge eating among women low in SBW ideology did not vary significantly as a function of trauma exposure and distress. The findings from the structural path analyses provide further evidence of SBW ideology’s moderating role. Several aspects of the model, particularly the unstandardized path coefficients, exhibited important differences when tested separately for women endorsing high and low levels of SBW ideology. Chief among these differences were that among women strongly endorsing the SBW image, stress exhibited strong positive relationships with emotional inhibition/regulation difficulties and self-silencing, and appeared to influence binge eating *through* its effects on these variables rather than via a direct effect (suggesting that the relationship between stress and binge eating was mediated by emotional inhibition/regulation difficulties and self-silencing). In contrast, among the women low in SBW ideology, stress was not as strongly related to emotional inhibition/regulation difficulties and self-silencing and instead had a *direct* effect on binge eating rather than acting through these other variables (i.e., the relationship between stress and binge eating was not mediated by these variables). Additionally, discriminatory stress appeared to play a more salient role for these women,
as the relationships between this variable and emotional inhibition/regulation difficulties and self-silencing was stronger than among the high SBW women. Further, key directional differences emerged such that discriminatory stress exhibited positive relationships with these variables among the women low in SBW ideology and negative relationships among the women strongly endorsing the SBW image.

The differential findings for stress and discriminatory stress for the two groups of women may be best understood in the context of culturally sanctioned coping. The SBW image, particularly in its extreme form, encompasses a set of expectations and prescriptions for African American women’s behavior; as such, some responses (e.g., feeling depressed, admitting to struggling, seeking mental health services) are viewed as inconsistent with these dictates and thus unacceptable, while other responses (e.g., use of spirituality and religious beliefs and practices; efforts to “keep on keepin’ on”) are deemed permissible and culturally congruent (Mitchell & Herring, 1998; Morgan, 1999).

Because the SBW image in its extreme form denies African American women permission to feel stress or emotional pain, a woman who has internalized these messages likely sees these feelings as unacceptable and feels pressure to be a superwoman who is (or is supposed to be) capable of handling everything (e.g., Mitchell & Herring, 1998). To acknowledge internally or to others that she is feeling stressed, overwhelmed, or struggling would be tantamount to admitting that she has fallen short of what is expected of her (Chisholm, 1996; Harris-Lacewell, 2001). Thus, she may respond to feelings of stress or emotional pain with particular emotional inhibition/regulation difficulties and self-silencing – namely, exhibiting nonacceptance of her “off-limits” emotions,
evidenced by difficulty acknowledging or admitting to the feelings, as well as efforts to present an outwardly different self (one that is competent, well-functioning, and handling it all, in contrast with internal feelings of stress, anxiety, self-doubt, and so forth). These strategies for dealing with stress and the accompanying emotions preserve her adherence to the SBW image and its standards, at least outwardly, because they are consistent with the dictates the image entails. Thus, women strongly endorsing SBW ideology would be expected to respond to stress with greater levels of nonacceptance of emotions and self-silencing. Women not endorsing these ideas (i.e., women low in SBW ideology), however, would be less likely to view acknowledging feelings of being stressed or overwhelmed as unacceptable, and thus would not be expected to respond to such feelings with nonacceptance or self-silencing.

The SBW image prescribes expected responses to discriminatory experiences that differ markedly from what is expected in response to stress. The SBW image is connected to and draws from several historical figures who have worked hard to combat oppression and have persevered in the face of adversity – women such as Sojourner Truth, Ida B. Wells, Harriet Tubman, and so forth. One key aspect of the legacy of these women and of the SBW symbol is to work toward preserving and strengthening the community by continuing to fight injustice; thus, for women who strongly identify with the SBW image and endorse its tenets, the image stipulates that they not remain silent in the face of oppression. It follows, then, that for these women who are high on SBW ideology, the more they are faced with discriminatory experiences the less likely they would be to engage in self-silencing behavior or denial of their anger and frustration
because it is inconsistent with the SBW mandates. Those women low in SBW ideology, in contrast, may be more likely to self-silence and to minimize or deny their frustration in the face of discriminatory experiences because doing so would not be violating deeply internalized cultural expectations.

These findings provide the first empirical support for the ideas put forth by researchers such as Harris-Lacewell (2001) and Herring and Mitchell (1998), who have argued that the SBW symbol in its extreme or excessive form prescribes a narrow range of acceptable responses in the face of stress and denies African American women the right to experience and express particular emotions or vulnerabilities. In addition, the results of the present study provide support for Beauboeuf-Lafontant’s (2003) hypothesis that internalization of the SBW image and its dictates can lead to emotional avoidance or suppression and ultimately eating problems as a means of “self-medication.” In many ways, these findings parallel those of Stice (1994), who in testing his model of eating pathology found that internalization of the thin ideal is a significant predictor of body dissatisfaction and eating problems in predominantly Caucasian populations. Thus, one interesting implication of the present findings is that just as sociocultural pressures to be thin lead to the internalization of the thin ideal and ultimately eating pathology (via increased body dissatisfaction) among Caucasian women, so too may environmental pressures to be strong lead to the internalization of the SBW ideology among African American women, which could put them at risk for binge eating by increasing their risk of emotional inhibition/regulation difficulties, self-silencing, and eating for psychological reasons. The regression analyses in the present study are consistent with such a model,
and taken together with the results of the structural path analyses, highlight that what may be one of the most salient constructs influencing African American women’s binge eating is their internalization and endorsement of the SBW ideology.

*Emotional Inhibition and Regulation Difficulties, Self-Silencing, and Eating for Psychological Reasons as Mediators*

Results of the multiple regression analyses and structural path analyses indicated that as predicted, emotional inhibition and regulation difficulties, self-silencing, and eating for psychological reasons each fully mediated the relationships between trauma, stress, discriminatory stress, and binge eating. These findings suggest that critical mechanisms or pathways by which traumatic, stressful, and discriminatory experiences influence African American women’s binge eating symptomatology are through increasing the likelihood or severity of emotion regulation difficulties, self-silencing behaviors, and the use of eating to fulfill psychological functions. It may be that these women are turning to eating as a way to manage the negative affect associated with their difficult experiences (e.g., Deaver et al., 2003; Thompson, 1996). This interpretation is consistent with the extensive literature documenting associations between emotional inhibition and regulation difficulties and binge eating (Cochrane et al., 1993; Jimerson et al., 1994; Troop et al., 1995; Zaitsoff et al., 2002) and positing a conceptualization of binge eating as a maladaptive attempt at regulating and managing negative affect (Arnow et al., 1995; Deaver et al., 2003; de Groot & Rodin, 1999; Gersheny & Thayer, 1999; Heatherton & Baumeister, 1991; Schwartz & Gay, 1996). To date, this research has been conducted on samples predominantly comprised of Caucasian women and thus it has
been unclear whether and to what extent the findings and underlying conceptual model apply to African American women.

The results of the present study, therefore, provide the first empirical support for an affective model of binge eating in African American women. As such, they suggest that the function of binge eating may be similar for African American and Caucasian women – that the behavior represents a strategy for regulating, managing, escaping, or avoiding negative affect. However, critical differences appear to be present in terms of the triggers or prompting environments for binge eating. For African American women, the results of the present study suggest that binge eating may be particularly likely to serve an affect regulation function among individuals who strongly identify with or endorse the SBW image and are struggling to find ways to cope with their affect and their difficult experiences that do not violate the expectations inherent in or encompassed by the symbol.

The findings from the structural path analyses provide further support for this interpretation. Among the women endorsing high levels of SBW ideology, stress was significantly related to both emotional inhibition/regulation difficulties and self-silencing, but was not directly related to binge eating symptomatology. Instead, stress’s relationship with binge eating appeared to be mediated by these other variables; in other words, stress was associated with binge eating symptomatology because it increased the likelihood or severity of emotion regulation difficulties and self-silencing among women strongly endorsing the SBW image. This finding likely reflects the idea that the SBW image prescribes a narrow range of acceptable coping strategies and responses to stress.
(e.g., Harris-Lacewell, 2001; Mitchell & Herring, 1998), and thus women strongly endorsing SBW ideology will be more likely to exhibit nonacceptance of emotions and self-silencing attitudes and behaviors when facing stress, which in turn renders them more susceptible to using eating to fulfill psychological functions because they lack few other adaptive alternatives.

These findings differ from those for the women endorsing low levels of SBW ideology. Among these women, in contrast, stress was not significantly related to either emotional inhibition/regulation difficulties or self-silencing. Further, stress was directly related to binge eating symptomatology among the low SBW women, suggesting that this construct is either directly related to binge eating or is related by a different (and as yet unidentified) mechanism among those African American women who do not strongly identify with the SBW image. Thus, SBW ideology appears to interact with mediating variables such as emotional inhibition/regulation difficulties and self-silencing in important ways. In particular, some of the identified mechanisms and pathways suggested by the present study may only apply to the binge eating of women endorsing high levels of SBW ideology.

Limitations

While the findings of the present study have the potential to enhance our understanding of binge eating among African American women, there are several methodological limitations that might impact the generalizability of the results. One limitation relates to the reliability and validity of some of the measures used, as well as their cultural relevance given that a few of the instruments (e.g., the Difficulties in
Emotion Regulation Scale, the Emotional Eating Scale) were developed and normed on predominantly Caucasian samples. Further, the poor measurement of the support-seeking and utilization variable precludes clarification of what role, if any, this construct plays in influencing African American women’s binge eating and whether this role differs based on the degree to which an individual has internalized the SBW dictates. In addition, the construct validity of the SBW ideology factor is unclear because this study represents the first attempt to empirically measure and investigate this construct. Although preliminary evidence of convergent validity is encouraging (e.g., expected positive correlations with emotional inhibition/regulation difficulties and self-silencing), further research is needed to determine the adequacy with which SBW ideology is assessed by using the measures from this study (the Efficacy of Help-Seeking Scale and two subscales from the Stereotypic Roles for Black Women Scale). Due to the conceptual overlap between the caretaking components of SBW ideology and the construct of unmitigated communion as operationalized by Helgeson (1993), it may be beneficial to add the Unmitigated Communion Scale to the three measures used in this study to closer approximate the construct of SBW ideology.

Another limitation relates to the sample size. Although the overall sample was sufficiently large for the analyses, once the sample was separated into high and low SBW participants, these groupings were considerably smaller, particularly given the complexity of the model and the number of parameters to be estimated. Thus, it is quite likely that the analyses lacked sufficient power to accurately test the hypothesized relationships. In particular, while the present findings suggest interesting possibilities
about SBW ideology’s potential role as a moderator, these conclusions should be tempered by the fact that the structural path analyses are based on two groups of fairly small numbers of participants (62 and 65). Thus, the results need to be interpreted with some caution until they are replicated in a larger sample with greater numbers of individuals comprising the high and low SBW ideology groups. An additional limitation related to the sample is that it was comprised of volunteers who may not be representative of African American women in general, and thus there are limitations with respect to the generalizability of the study’s findings. Offsetting this concern, however, is the fact that the sample was relatively heterogeneous (particularly in terms of age, socioeconomic status); this heterogeneity may temper some of the limitations to the study’s external validity.

Finally, the degree to which the pathways proposed in the model are specific to African American women is unclear. Because no simultaneous investigation of these relationships has been undertaken in any sample of women, regardless of ethnicity, it is possible that many or perhaps all of the proposed paths might hold for other ethnic groups of women.

*Future Directions and Implications*

Future research should attempt to replicate the model (and its modifications) in a larger sample of African American women, one that possesses sufficient power to adequately test the hypothesized relationships. In addition, refining the assessment of support-seeking and utilization will be important, as it will allow for determination of whether this construct does influence binge eating among African American women.
Further, investigating the potential buffering or protective role of spirituality and religious coping, which is likely more culturally congruent/sanctioned than other potential responses, will be a valuable next step in building a more comprehensive understanding of African American women’s binge eating.

The present study will hopefully spark dialogue and contemplation about the ways in which we conceptualize binge eating among African American women and ultimately move us closer to developing more accurate, culturally-informed conceptualizations. Beyond these theoretical and conceptual implications, though, the present study can also begin to inform our assessment, treatment, and prevention efforts. First, approaching treatment from a culturally competent framework is critical. Adopting such an underlying conceptual foundation entails more than the clinician having an awareness of, understanding of, and appreciation for cultural factors and influences (e.g., Harris & Kuba, 1997; Sue, 2001). Instead, adopting this kind of framework calls for integrating culture into every aspect of treatment and explicitly discussing how factors such as cultural norms, expectations, and messages, ethnic identity and affiliation, racial socialization, and discriminatory experiences have impacted the individual and how these constructs might bear on the presenting problems. Further, it is critically important to consider how each individual client is influenced by and differs from her culture, keeping in mind both intra- and intergroup variability, and to guard against assuming a monolithic, homogeneous African American culture or uniform experiences that affect individuals in similar ways. Thus, taking care to not oversimplify culture in interpreting
the results from this study, developing further studies, building theories, and treating
African American women is essential.

Given what we already know about the SBW symbol, it is quite likely that endorsement of the image might affect not only African American women’s willingness to seek treatment, but also their clinical presentation if they do seek services. For African American women who have internalized the SBW image and feel pressure to conform to its prescriptions, they may be extremely reluctant to seek mental health services because doing so essentially entails admitting failings or shortcomings and is not widely accepted in many aspects of their communities, especially because “strong black women don’t go to therapy” (e.g., Danquah, 1998). Thus, they are unlikely to present for therapy and instead may continue struggling and suffering in silence. If these women do eventually present for therapy, once there it may be difficult for them to admit to or acknowledge emotional distress or concerns about binge eating behavior. Therefore, they may underreport, minimize, or attempt to portray themselves as “keeping it all together,” a front that belies their actual internal experience.

Further, if an African American woman does present for treatment and is exhibiting difficulties with binge eating, our initial findings suggest selecting particular targets for intervention and utilizing specific, tailored intervention strategies in order to increase the likely efficacy of treatment efforts. For example, using techniques such as cognitive restructuring to address the rigidity/overinternalization of the SBW image and its dictates may help clients move toward adopting more balanced beliefs with a less exacting toll and finding ways to maintain connection to the positive aspects of the SBW
image without being so vulnerable to its negative aspects. Because emotional inhibition and regulation difficulties appear to play such a salient role, employing mindfulness and acceptance-based interventions and targeting emotion regulation specifically via skills-based interventions such as Dialectical Behavior Therapy would likely be beneficial in helping clients move away from an overreliance on emotional avoidance and suppression. Providing clients with a broader repertoire of adaptive alternatives for coping with negative affect will hopefully decrease their reliance on using eating to fulfill psychological needs.

The present study represents an important first step toward developing accurate conceptualizations of and interventions for binge eating among African American women. Traumatic, stressful, and discriminatory experiences appear to play a significant role; further, the effects of these constructs appear to be strongly influenced by the degree to which the individual woman identifies with the SBW image and the presence and intensity of emotional inhibition/regulation difficulties, self-silencing, and eating for psychological reasons. However, we are still in the earliest stages of understanding African American women’s binge eating from a culturally competent framework, and our treatment and prevention efforts lag even farther behind. In light of the high prevalence of binge eating and its serious emotional and physical consequences, it is imperative that we continue striving for better conceptualization, treatment, and prevention efforts to address this serious problem; our hope is that this study will contribute to this valuable and much needed undertaking.
REFERENCES


women with co-occurring substance use and mental health disorders and a history of interpersonal violence. *Journal of Behavioral Health Services Research, 32*, 113-127.


Neale Hurston, Z. (1937). *Their eyes were watching God*. Greenwich, CT: Fawcett.


*The Journal of Communication, 50*, 100-118.

*European Eating Disorders Review, 10*, 51-60.
APPENDIX A

MEASURES
Demographic Information

Age _____ Height _____ Weight _____

Education level (check highest level obtained):
___ 1) less than 8th grade
___ 2) 8th grade
___ 3) some high school
___ 4) high school
___ 5) trade school
___ 6) some college
___ 7) 2-year college
___ 8) 4-year college
___ 9) Master’s level
___ 10) Doctoral level

Employment status (check one):
___ 1) not currently employed
___ 2) employed part-time
___ 3) employed full-time
___ 4) other

Occupation/job:

_____________________________

Your Annual Income (check one):
___ 1) Less than $5,000
___ 2) $5,000 to $9,999
___ 3) $10,000 to $14,999
___ 4) $15,000 to $24,999
___ 5) $25,000 to $34,999
___ 6) $35,000 to $49,999
___ 7) $50,000 to $74,999
___ 8) $75,000 to $99,999
___ 9) $100,000 to $149,999
___ 10) $150,000 or more

Your Household’s Annual Income (check one):
___ 1) Less than $5,000
___ 2) $5,000 to $9,999
___ 3) $10,000 to $14,999
___ 4) $15,000 to $24,999
___ 5) $25,000 to $34,999
___ 6) $35,000 to $49,999
___ 7) $50,000 to $74,999
___ 8) $75,000 to $99,999
___ 9) $100,000 to $149,999
___ 10) $150,000 or more

Who lives in your household?

_____________________________

Your ethnic origin (check one):
___ 1) American Indian or Alaskan Native
___ 2) African American/Black
___ 3) Asian, Asian American, Asian Indian, or Pacific Islander
   ___ Asian Indian
   ___ Chinese
   ___ Japanese
   ___ Korean
   ___ Filipino
   ___ Other Asian (specify group):
___ 4) Caucasian/White
___ 5) Hispanic/Latina
   ___ Mexican, Mexican American, Chicana
   ___ Puerto Rican
   ___ Cuban
   ___ Other Hispanic/Latina (specify group):
___ 6) Other (please specify):

Your nation of origin (Where you were born):

_____________________________

Mother’s ethnic origin (check one):
___ 1) American Indian or Alaskan Native
___ 2) African American/Black
___ 3) Asian, Asian American, Asian Indian, or Pacific Islander
   ___ Asian Indian
   ___ Chinese
   ___ Japanese
   ___ Korean
   ___ Filipino
   ___ Other Asian (specify group):
___ 4) Caucasian/White
___ 5) Hispanic/Latina
   ___ Mexican, Mexican American, Chicana
   ___ Puerto Rican
   ___ Cuban
   ___ Other Hispanic/Latina (specify group):
___ 6) Other (please specify):

Mother’s nation of origin (Where she was born):

_____________________________
Mother's occupation/job: __________________________

Mother's education level (check highest level obtained):
___ 1) less than 8th grade
___ 2) 8th grade
___ 3) some high school
___ 4) high school
___ 5) trade school
___ 6) some college
___ 7) 2-year college
___ 8) 4-year college
___ 9) Master's level
___ 10) Doctoral level

Father's occupation/job: __________________________

Father's nation of origin (Where he was born): __________________________

Father's education level (check highest level obtained):
___ 1) less than 8th grade
___ 2) 8th grade
___ 3) some high school
___ 4) high school
___ 5) trade school
___ 6) some college
___ 7) 2-year college
___ 8) 4-year college
___ 9) Master's level
___ 10) Doctoral level

Have you ever sought or received treatment for an eating problem?
___ 1) Yes (please specify): __________________________
___ 2) No

Have you ever been diagnosed with an eating disorder?
___ 1) Yes (please specify): __________________________
___ 2) No

What is your current marital status?
___ 1) Never married
___ 2) Married
___ 3) Separated/divorced
___ 4) Widowed
___ 5) Living with partner

Do you have children?
___ 1) Yes
   How many? ______
___ 2) No
Life Stressors Checklist–Revised (LSC-R)

1. Have you ever been in a serious disaster (for example, a massive earthquake, hurricane, tornado, fire, explosion)?

   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time? 1 2 3 4 5 not at all moderately extremely
   f. How much has it affected your life in the past year? 1 2 3 4 5 not at all moderately extremely

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)?

   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time? 1 2 3 4 5 not at all moderately extremely
   f. How much has it affected your life in the past year? 1 2 3 4 5 not at all moderately extremely

3. Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)?

   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time? 1 2 3 4 5 not at all moderately extremely
   f. How much has it affected your life in the past year? 1 2 3 4 5 not at all moderately extremely
4. Was a close family member ever sent to jail?  
   YES  NO
   
   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  YES  NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  YES  NO
   e. How upsetting was the event at the time?  
      1     2     3     4     5  
      not at all moderately extremely
   f. How much has it affected your life in the past year?  
      1     2     3     4     5  
      not at all moderately extremely

5. Have you ever been sent to jail?  
   YES  NO
   
   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  YES  NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  YES  NO
   e. How upsetting was the event at the time?  
      1     2     3     4     5  
      not at all moderately extremely
   f. How much has it affected your life in the past year?  
      1     2     3     4     5  
      not at all moderately extremely

6. Were you ever put in foster care or put up for adoption?  
   YES  NO
   
   **If you answered yes:**
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  YES  NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  YES  NO
   e. How upsetting was the event at the time?  
      1     2     3     4     5  
      not at all moderately extremely
   f. How much has it affected your life in the past year?  
      1     2     3     4     5  
      not at all moderately extremely
7. Did your parents ever separate or divorce while you were living with them? YES NO

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? ______
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1  2  3  4  5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1  2  3  4  5
      not at all moderately extremely

8. Have you ever been separated or divorced? YES NO

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? ______
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1  2  3  4  5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1  2  3  4  5
      not at all moderately extremely

9. Have you ever had serious money problems (for example, not enough money for food or place to live)? YES NO

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? ______
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1  2  3  4  5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1  2  3  4  5
      not at all moderately extremely
10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)?

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time? 
     1 2 3 4 5 
     not at all moderately extremely
  f. How much has it affected your life in the past year? 
     1 2 3 4 5 
     not at all moderately extremely

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were “no good”)?

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time? 
     1 2 3 4 5 
     not at all moderately extremely
  f. How much has it affected your life in the past year? 
     1 2 3 4 5 
     not at all moderately extremely

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time? 
     1 2 3 4 5 
     not at all moderately extremely
  f. How much has it affected your life in the past year? 
     1 2 3 4 5 
     not at all moderately extremely
13. Have you ever had an abortion or miscarriage (lost your baby)?

If you answered yes:

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES  NO
d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES  NO
e. How upsetting was the event at the time?
   1  2  3  4  5
   not at all moderately extremely
f. How much has it affected your life in the past year?
   1  2  3  4  5
   not at all moderately extremely

14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation or kidnapping)?

If you answered yes:

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES  NO
d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES  NO
e. How upsetting was the event at the time?
   1  2  3  4  5
   not at all moderately extremely
f. How much has it affected your life in the past year?
   1  2  3  4  5
   not at all moderately extremely

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk)?

If you answered yes:

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES  NO
d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES  NO
e. How upsetting was the event at the time?
   1  2  3  4  5
   not at all moderately extremely
f. How much has it affected your life in the past year?
   1  2  3  4  5
   not at all moderately extremely
16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, Alzheimer’s disease, AIDS, felt like killing him/herself, hospitalized because of nerve problems, can’t hear, see, walk)?

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely

17. Has someone close to you died suddenly or unexpectedly (for example, an accident, sudden heart attack, murder or suicide)?

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely
18. Has someone close to you died (do not include those who died suddenly or unexpectedly)?

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely

19. When you were young (before age 16), did you ever see violence between family members (for example, hitting, kicking, slapping, punching)?

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely

20. Have you ever seen a robbery, mugging, or attack taking place?

If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely
21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know? YES NO

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time?
     1  2  3  4  5
     not at all moderately extremely
  f. How much has it affected your life in the past year?
     1  2  3  4  5
     not at all moderately extremely

22. Before age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)? YES NO

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time?
     1  2  3  4  5
     not at all moderately extremely
  f. How much has it affected your life in the past year?
     1  2  3  4  5
     not at all moderately extremely

23. After age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)? YES NO

If you answered yes:
  a. How old were you when this first began? _____
  b. How old were you when it ended? _____
  c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
  d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
  e. How upsetting was the event at the time?
     1  2  3  4  5
     not at all moderately extremely
  f. How much has it affected your life in the past year?
     1  2  3  4  5
     not at all moderately extremely
24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a coworker, a boss, a customer, another student, a teacher)?

   If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely

25. Before age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn’t?  YES NO

   If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely

26. After age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn’t?  YES NO

   If you answered yes:
   a. How old were you when this first began? _____
   b. How old were you when it ended? _____
   c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   e. How upsetting was the event at the time?
      1 2 3 4 5
      not at all moderately extremely
   f. How much has it affected your life in the past year?
      1 2 3 4 5
      not at all moderately extremely
27. **Before age 16, did you ever have sex (oral, anal, genital) when you didn’t want to because someone forced you in some way or threatened to harm you if you didn’t?**

**If you answered yes:**

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How upsetting was the event at the time? 
   
   1 2 3 4 5
   
   not at all moderately extremely
f. How much has it affected your life in the past year? 
   
   1 2 3 4 5
   
   not at all moderately extremely

28. **After age 16, did you ever have sex (oral, anal, genital) when you didn’t want to because someone forced you in some way or threatened to harm you if you didn’t?**

**If you answered yes:**

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How upsetting was the event at the time? 
   
   1 2 3 4 5
   
   not at all moderately extremely
f. How much has it affected your life in the past year? 
   
   1 2 3 4 5
   
   not at all moderately extremely

29. **Are there any events we did not include that you would like to mention?** YES NO

**If you answered yes:** What was the event? 

a. How old were you when this first began? _____
b. How old were you when it ended? _____
c. At the time of the event did you believe that you or someone else could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How upsetting was the event at the time? 
   
   1 2 3 4 5
   
   not at all moderately extremely
f. How much has it affected your life in the past year? 
   
   1 2 3 4 5
   
   not at all moderately extremely
30. Have any of the events mentioned above ever happened to someone close to you so that even though you didn’t see it or experience the event yourself, you were seriously disturbed by it?  

If you answered yes: What was the event?  

a. How old were you when this first began? _____  
b. How old were you when it ended? _____  
c. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO  
d. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO  
e. How upsetting was the event at the time?  
   not at all moderately extremely  

f. How much has it affected your life in the past year?  
   not at all moderately extremely
Sexual Experiences Survey (SES)

1. Did you give in to sex play (fondling, kissing, or petting, but not intercourse) when you didn’t want to because you were overwhelmed by a male’s continual arguments and pressure?  

If you answered yes:
   a. How many times did this occur? 1 time 2 times 3 times 4 or more times
   b. How old were you when this first began? _____
   c. How old were you when it ended? _____
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? 1 2 3 4 5 not at all moderately extremely
   g. How much has it affected your life in the past year? 1 2 3 4 5 not at all moderately extremely

2. Did you have sex play (fondling, kissing, or petting, but not intercourse) when you didn’t want to because a male used his position of authority (boss, teacher, camp counselor, supervisor) to make you?  

If you answered yes:
   a. How many times did this occur? 1 time 2 times 3 times 4 or more times
   b. How old were you when this first began? _____
   c. How old were you when it ended? _____
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? 1 2 3 4 5 not at all moderately extremely
   g. How much has it affected your life in the past year? 1 2 3 4 5 not at all moderately extremely

3. Did you have sex play (fondling, kissing, or petting, but not intercourse) when you didn’t want to because a male threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?  

If you answered yes:
   a. How many times did this occur? time 2 times 3 times 4 or more times
   b. How old were you when this first began? _____
   c. How old were you when it ended? _____
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? not at all moderately extremely
   g. How much has it affected your life in the past year? not at all moderately extremely
4. Did you have a male attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn’t want to by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did not occur?  

If you answered yes:  
a. How many times did this occur?  
   1 time  2 times  3 times  4 or more times  
b. How old were you when this first began?  
c. How old were you when it ended?  
d. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  
   YES  NO  
e. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  
   YES  NO  
f. How upsetting was the event at the time?  
   not at all  moderately  extremely  
g. How much has it affected your life in the past year?  
   not at all  moderately  extremely

5. Did you have a male attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn’t want to by giving you alcohol or drugs, but intercourse did not occur?  

If you answered yes:  
   a. How many times did this occur?  
      1 time  2 times  3 times  4 or more times  
   b. How old were you when this first began?  
   c. How old were you when it ended?  
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  
      YES  NO  
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  
      YES  NO  
   f. How upsetting was the event at the time?  
      not at all  moderately  extremely  
   g. How much has it affected your life in the past year?  
      not at all  moderately  extremely

6. Did you give in to sexual intercourse when you didn’t want to because you were overwhelmed by a male’s continual arguments and pressure?  

If you answered yes:  
   a. How many times did this occur?  
      1 time  2 times  3 times  4 or more times  
   b. How old were you when this first began?  
   c. How old were you when it ended?  
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  
      YES  NO  
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror?  
      YES  NO  
   f. How upsetting was the event at the time?  
      not at all  moderately  extremely  
   g. How much has it affected your life in the past year?  
      not at all  moderately  extremely
7. Did you have sexual intercourse when you didn’t want to because a male used his position of authority (boss, teacher, camp counselor, supervisor) to make you? 

If you answered yes:
   a. How many times did this occur? 1 time 2 times 3 times 4 or more times
   b. How old were you when this first began? ______
   c. How old were you when it ended? ______
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? 1 not at all 2 moderately 3 extremely 4 5
   g. How much has it affected your life in the past year? 1 not at all 2 moderately 3 extremely 4 5

8. Did you have sexual intercourse when you didn’t want to because a male gave you alcohol or drugs? 

If you answered yes:
   a. How many times did this occur? 1 time 2 times 3 times 4 or more times
   b. How old were you when this first began? ______
   c. How old were you when it ended? ______
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? 1 not at all 2 moderately 3 extremely 4 5
   g. How much has it affected your life in the past year? 1 not at all 2 moderately 3 extremely 4 5

9. Did you have sexual intercourse when you didn’t want to because a male threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you? 

If you answered yes:
   a. How many times did this occur? 1 time 2 times 3 times 4 or more times
   b. How old were you when this first began? ______
   c. How old were you when it ended? ______
   d. At the time of the event did you believe that you or someone else could be killed or seriously harmed? YES NO
   e. At the time of the event did you experience feelings of intense helplessness, fear, or horror? YES NO
   f. How upsetting was the event at the time? 1 not at all 2 moderately 3 extremely 4 5
   g. How much has it affected your life in the past year? 1 not at all 2 moderately 3 extremely 4 5
10. Did you have sexual acts (anal or oral intercourse or penetration by objects other than the penis) when you didn’t want to because a male threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?  

If you answered yes:

a. How many times did this occur?  
   1 time  2 times  3 times  4 or more times
b. How old were you when this first began?  
c. How old were you when it ended?  
d. At the time of the event did you believe that you or someone else could be killed or seriously harmed?  
   YES  NO

At the time of the event did you experience feelings of intense helplessness, fear, or horror?  

f. How upsetting was the event at the time?  
   1  2  3  4  5  
   not at all  moderately  extremely

g. How much has it affected your life in the past year?  
   1  2  3  4  5  
   not at all  moderately  extremely
Survey of Recent Life Experiences (SRLE)

Following is a list of experiences which many people have some time or other. Please indicate for each experience how much it has been a part of your life over the past month. Put a “1” in the space provided next to an experience if it was not at all part of your life over the past month (e.g., “trouble with mother in law – 1”); “2” for an experience which was only slightly part of your life over that time; “3” for an experience which was distinctly part of your life; and “4” for an experience which was very much part of your life over the past month.

Intensity of Experience over Past Month
1 = not at all part of my life
2 = only slightly part of my life
3 = distinctly part of my life
4 = very much part of my life

1. Disliking your daily activities
2. Lack of privacy
3. Disliking your work
4. Ethnic or racial conflict
5. Being let down or disappointed by friends
6. Conflict with supervisor(s) at work
7. Social rejection
8. Too many things to do at once
9. Being taken for granted
10. Financial conflicts with family members
11. Having your trust betrayed by a friend
12. Separation from people you care about
13. Having your contributions overlooked
14. Struggling to meet your own standards of performance and accomplishment
15. Being taken advantage of
16. Not enough leisure time
17. Financial conflicts with friends or fellow workers
18. Struggling to meet other people’s standards of performance and accomplishment
19. Having your actions misunderstood by others
20. Cash-flow difficulties
21. A lot of responsibilities
22. Dissatisfaction with work
23. Decisions about intimate relationship(s)
24. Not enough time to meet your obligations
25. Dissatisfaction with your mathematical ability
26. Financial burdens
27. Lower evaluation of your work than you think you deserve
28. Experiencing high levels of noise
29. Lower evaluation of your work than you hoped for
30. Conflicts with family member(s)
31. Finding your work too demanding
32. Conflicts with friend(s)
33. Hard effort to get ahead
34. Trying to secure loan(s)
Intensity of Experience over Past Month
1 = not at all part of my life
2 = only slightly part of my life
3 = distinctly part of my life
4 = very much part of my life

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>35. Getting “ripped off” or cheated in the purchase of goods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Social isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Being ignored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Dissatisfaction with your physical appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Unsatisfactory housing conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Finding work uninteresting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Failing to get money you expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Gossip about someone you care about</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Dissatisfaction with your physical fitness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Gossip about yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Difficulty dealing with modern technology (e.g., computers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Car problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Hard work to look after and maintain home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Perceived Stress Scale (PSS)

The questions in this next scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don’t try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate. For each question, choose from the following alternatives:

0 = never  1 = almost never  2 = sometimes  3 = fairly often  4 = very often

In the last month, how often have you been upset because of something that happened unexpectedly?  
0  1  2  3  4

In the last month, how often have you felt that you were unable to control the important things in your life?  
0  1  2  3  4

In the last month, how often have you felt nervous and “stressed”?  
0  1  2  3  4

In the last month, how often have you dealt successfully with irritating life hassles?  
0  1  2  3  4

In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?  
0  1  2  3  4

In the last month, how often have you felt confident about your ability to handle your personal problems?  
0  1  2  3  4

In the last month, how often have you felt that things were going your way?  
0  1  2  3  4

In the last month, how often have you found that you could not cope with all the things that you had to do?  
0  1  2  3  4

In the last month, how often have you been able to control irritations in your life?  
0  1  2  3  4

In the last month, how often have you felt that you were on top of things?  
0  1  2  3  4

In the last month, how often have you been angered because of things that happened that were outside of your control?  
0  1  2  3  4

In the last month, how often have you found yourself thinking about things that you have to accomplish?  
0  1  2  3  4

In the last month, how often have you been able to control the way you spend your time?  
0  1  2  3  4

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?  
0  1  2  3  4
Schedule of Racist Events (SRE)

We are interested in your experiences with racism. As you answer the questions below, please think about your ENTIRE LIFE, from when you were a child to the present. For each question, please circle the number that best captures the things that have happened to you. Answer each question TWICE, once for what has happened to you IN THE PAST YEAR, and once for what YOUR ENTIRE LIFE HAS BEEN LIKE. Use these numbers:

Circle 1 = If this has NEVER happened to you
Circle 2 = If this has happened ONCE IN A WHILE (less than 10% of the time)
Circle 3 = If this has happened SOMETIMES (10-25% of the time)
Circle 4 = If this has happened A LOT (26-49% of the time)
Circle 5 = If this has happened MOST OF THE TIME (50-70% of the time)
Circle 6 = If this has happened ALMOST ALL OF THE TIME (more than 70% of the time)

1. How many times have you been treated unfairly by teachers and professors because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   How many times IN THE PAST YEAR? 1 2 3 4 5 6
   How stressful was this for you? Not at all 1 2 3 4 5 6

2. How many times have you been treated unfairly by your employers, bosses and supervisors because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   How many times IN THE PAST YEAR? 1 2 3 4 5 6
   How stressful was this for you? Not at all 1 2 3 4 5 6

3. How many times have you been treated unfairly by your coworkers, fellow students and colleagues because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   How many times IN THE PAST YEAR? 1 2 3 4 5 6
   How stressful was this for you? Not at all 1 2 3 4 5 6

4. How many times have you been treated unfairly by people in service jobs (store clerks, waiters, bartenders, bank tellers and others) because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   How many times IN THE PAST YEAR? 1 2 3 4 5 6
   How stressful was this for you? Not at all 1 2 3 4 5 6

5. How many times have you been treated unfairly by strangers because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   How many times IN THE PAST YEAR? 1 2 3 4 5 6
   How stressful was this for you? Not at all 1 2 3 4 5 6
1 = never 2 = once in a while 3 = sometimes 4 = a lot 5 = most of the time 6 = almost all the time

6. How many times have you been treated unfairly by people in helping jobs (doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers and others) because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6
   How stressful was this for you? Not at all Extremely 1 2 3 4 5 6

7. How many times have you been treated unfairly by neighbors because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6
   How stressful was this for you? Not at all Extremely 1 2 3 4 5 6

8. How many times have you been treated unfairly by institutions (schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office and others) because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6
   How stressful was this for you? Not at all Extremely 1 2 3 4 5 6

9. How many times have you been treated unfairly by people you thought were your friends because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6
   How stressful was this for you? Not at all Extremely 1 2 3 4 5 6

10. How many times have you been accused or suspected of doing something wrong (such as stealing, cheating, not doing your share of the work, or breaking the law) because of your race or ethnicity?
    How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
    How many times IN THE PAST YEAR?  1 2 3 4 5 6
    How stressful was this for you? Not at all Extremely 1 2 3 4 5 6

11. How many times have people misunderstood your intentions and motives because of your race or ethnicity?
    How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
    How many times IN THE PAST YEAR?  1 2 3 4 5 6
    How stressful was this for you? Not at all Extremely 1 2 3 4 5 6
1 = never  2 = once in a while  3 = sometimes  4 = a lot  5 = most of the time  6 = almost all the time

12. How many times did you want to tell someone off for being racist but didn’t say anything?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

13. How many times have you been really angry about something racist that was done to you?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

14. How many times were you forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some racist thing that was done to you?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

15. How many times have you been called a racist name like nigger, coon, jungle bunny or other names?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

16. How many times have you gotten into an argument or a fight about something racist that was done to you or done to somebody else?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

17. How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because of your race or ethnicity?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6

   How stressful was this for you?  Not at all  2  3  4  5  6

18. How different would your life be now if you HAD NOT BEEN treated in a racist and unfair way:

   THROUGHOUT YOUR ENTIRE LIFE:
   The same as   A little   Different in   Different in   Different in   Totally
   it is now   different   a few ways   a lot of ways   most ways   different
   1  2  3  4  5  6
IN THE PAST YEAR:

<table>
<thead>
<tr>
<th>The same as</th>
<th>A little different</th>
<th>Different in a few ways</th>
<th>Different in a lot of ways</th>
<th>Different in most ways</th>
<th>Totally different</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Schedule of Sexist Events (SSE)

We are interested in your experiences with sexism. As you answer the questions below, please think about your ENTIRE LIFE, from when you were a child to the present. For each question, please circle the number that best captures the things that have happened to you. Answer each question TWICE, once for what has happened to you IN THE PAST YEAR, and once for what YOUR ENTIRE LIFE HAS BEEN LIKE. Use these numbers:

Circle 1 = If the event has NEVER happened to you  
Circle 2 = If the event happened ONCE IN A WHILE (less than 10% of the time)  
Circle 3 = If the event happened SOMETIMES (10-25% of the time)  
Circle 4 = If the event happened A LOT (26-49% of the time)  
Circle 5 = If the event happened MOST OF THE TIME (50-70% of the time)  
Circle 6 = If the event happened ALMOST ALL OF THE TIME (more than 70% of the time)

1. How many times have you been treated unfairly by teachers or professors because you are a woman?
   - How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   - How many times IN THE PAST YEAR? 1 2 3 4 5 6
   - How stressful was this for you? Not at all 1 2 3 4 5 6

2. How many times have you been treated unfairly by your employer, boss, or supervisors because you are a woman?
   - How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   - How many times IN THE PAST YEAR? 1 2 3 4 5 6
   - How stressful was this for you? Not at all 1 2 3 4 5 6

3. How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are a woman?
   - How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   - How many times IN THE PAST YEAR? 1 2 3 4 5 6
   - How stressful was this for you? Not at all 1 2 3 4 5 6

4. How many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, mechanics, and others) because you are a woman?
   - How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
   - How many times IN THE PAST YEAR? 1 2 3 4 5 6
   - How stressful was this for you? Not at all 1 2 3 4 5 6
1 = never  2 = once in a while  3 = sometimes  4 = a lot  5 = most of the time  6 = almost all the time

5. How many times have you been treated unfairly by strangers because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?  Not at all  1  2  3  4  5  6

6. How many times have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists, and others) because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?  Not at all  1  2  3  4  5  6

7. How many times have you been treated unfairly by neighbors because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?  Not at all  1  2  3  4  5  6

8. How many times have you been treated unfairly by your boyfriend, husband, or other important man in your life because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?  Not at all  1  2  3  4  5  6

9. How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?  Not at all  1  2  3  4  5  6

10. How many times have you been treated unfairly by your family because you are a woman?
    How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
    How many times IN THE PAST YEAR?  1  2  3  4  5  6
    How stressful was this for you?  Not at all  1  2  3  4  5  6
1 = never   2 = once in a while   3 = sometimes   4 = a lot   5 = most of the time   6 = almost all the time

11. How many times have people made inappropriate or unwanted sexual advances to you because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6

12. How many times have people failed to show you the respect that you deserve because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6

13. How many times have you wanted to tell someone off for being sexist?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6

14. How many times have you been really angry about something sexist that was done to you?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6

15. How many times were you forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some sexist thing that was done to you?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6

16. How many times have you been called a sexist name like bitch, cunt, chick, or other names?
   How many times IN YOUR ENTIRE LIFE?  1  2  3  4  5  6
   How many times IN THE PAST YEAR?  1  2  3  4  5  6
   How stressful was this for you?      Not at all  Extremely 1  2  3  4  5  6
135

1 = never  2 = once in a while  3 = sometimes  4 = a lot  5 = most of the time  6 = almost all the time

17. How many times have you gotten into an argument or a fight about something sexist that was done or said to you or done to somebody else?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6

   How stressful was this for you?  Not at all  1 2 3 4 5 Extremely 6

18. How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are a woman?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6

   How stressful was this for you?  Not at all  1 2 3 4 5 Extremely 6

19. How many times have you heard people making sexist jokes or degrading sexual jokes?
   How many times IN YOUR ENTIRE LIFE?  1 2 3 4 5 6
   How many times IN THE PAST YEAR?  1 2 3 4 5 6

   How stressful was this for you?  Not at all  1 2 3 4 5 Extremely 6

20. How different would your life be now if you HAD NOT BEEN treated in a sexist and unfair way?

   THROUGHOUT YOUR ENTIRE LIFE:
   The same as  1
   A little different  2
   Different in a few ways  3
   Different in a lot of ways  4
   Different in most ways  5
   Totally different  6

   IN THE PAST YEAR:
   The same as  1
   A little different  2
   Different in a few ways  3
   Different in a lot of ways  4
   Different in most ways  5
   Totally different  6
Stereotypic Roles for Black Women Scale (SRBWS)

This is a scale to determine attitudes and beliefs. There are no right or wrong answers. Please use the following scale to complete the questions.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Black women are often loud and obnoxious.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Black women are all about sex.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Black women have to be strong to survive.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Black women need to nag others to get a response.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Black women will use sex to get what they want.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Men can be controlled with sex.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>If given a chance, Black women will put down Black men.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Black women are often treated as sex objects.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I am often expected to take care of family members.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>If I fall apart, I will be a failure.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Black women are usually angry with others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I often put aside my own needs to help others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I often feel ignored by others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I find it difficult to ask others for help.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I feel guilty when I put my own needs before others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I do not want others to know if I experience a problem.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>People often expect me to take care of them.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>People respond to me more if I am loud and angry.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I tell others that I am fine when I am depressed or down.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>People treat me as if I am a sex object.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>It is difficult for me to share problems with others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I should not expect nurturing from others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I am hardly ever satisfied.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Black women are out to get your man.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I often have to put someone in their place, read them, or check them.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Young Black women are gold-diggers.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I often threaten to cuss someone out.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Sex is a weapon.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>I am overworked, overwhelmed, and/or underappreciated.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Black women are demanding.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>I am always helping someone else.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>I will let people down if I take time out for myself.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>It is easy for me to tell other people my problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I feel guilty if I cannot help someone.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

“Mammy” Stereotype: items 12, 15, 17, 22, 34
“Superwoman” Stereotype: items 3, 9, 10, 14, 16, 19, 21, 29, 31, 32, 33 (reverse-coded)
“Sapphire” Stereotype: items 1, 4, 7, 11, 13, 18, 23, 25, 27, 30
“Jezebel” Stereotype: items 2, 5, 6, 8, 20, 24, 26, 28

Efficacy of Help-Seeking Scale (EHSS)
For the next set of questions, please rate the extent of your personal agreement with each of the following statements.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It is better to take care of your own problems than to rely on others for help.</td>
<td>Agree Strongly</td>
<td>Agree Somewhat</td>
<td>Disagree Somewhat</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Accepting help from other people makes you feel like you owe them something in return.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>You shouldn’t offer someone help unless they ask for it first.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Just talking over your worries with someone can make you feel better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Admitting hardships to others is a sign of weakness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Opening up to others allows them to take advantage of you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
UCLA Social Support Inventory (UCLA-SSI)

Support Seeking: In this set of questions, we are interested in how often you have actually sought support from people. For each group, choose the number that best describes how often you have sought support from that group overall. Use the following scale:

1        2  3         4   5        (7 = Not applicable)
Never        Sometimes        Very often

1. How often in the past 6 months have you actually sought money, housing, food, or other goods from the following individuals?

   _____ Spouse/partner
   _____ Parents
   _____ Siblings
   _____ Children
   _____ Other relatives
   _____ Friends
   _____ Co-workers/neighbors
   _____ Caseworkers/social workers
   _____ Therapists/doctors
   _____ Religious/charitable groups

2. How often in the past 6 months have you actually sought information or advice from the following individuals?

   _____ Spouse/partner
   _____ Parents
   _____ Siblings
   _____ Children
   _____ Other relatives
   _____ Friends
   _____ Co-workers/neighbors
   _____ Caseworkers/social workers
   _____ Therapists/doctors
   _____ Religious/charitable groups

3. How often in the past 6 months have you actually sought help with day-to-day tasks (such as a ride to places or a sitter for a child) from the following individuals?

   _____ Spouse/partner
   _____ Parents
   _____ Siblings
   _____ Children
   _____ Other relatives
   _____ Friends
   _____ Co-workers/neighbors
   _____ Caseworkers/social workers
   _____ Therapists/doctors
   _____ Religious/charitable groups

4. How often in the past 6 months have you actually sought love, caring, understanding, or reassurance from the following individuals?

   _____ Spouse/partner
   _____ Parents
   _____ Siblings
   _____ Children
   _____ Other relatives
   _____ Friends
   _____ Co-workers/neighbors
   _____ Caseworkers/social workers
   _____ Therapists/doctors
   _____ Religious/charitable groups

5. To what extent do you feel the following individuals are available to give you love, caring, understanding, or reassurance?

   _____ Spouse/partner
   _____ Parents
   _____ Siblings
   _____ Children
   _____ Other relatives
   _____ Friends
   _____ Co-workers/neighbors
   _____ Caseworkers/social workers
   _____ Therapists/doctors
   _____ Religious/charitable groups
**Willingness to Seek Support:**

The previous set of questions was interested in how often you *actually sought* support from others. In this next set of questions, please indicate how *willing* you are to *seek support* from others. For each group, choose the number that best describes how willing you are to seek support from that group overall. Use the following scale:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>(7 = Not applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. How *willing* are you to seek help with day-to-day tasks (such as a ride to places or a sitter for a child) from the following individuals?

<table>
<thead>
<tr>
<th>_____ Spouse/partner</th>
<th>_____ Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Parents</td>
<td>_____ Co-workers/neighbors</td>
</tr>
<tr>
<td>_____ Siblings</td>
<td>_____ Caseworkers/social workers</td>
</tr>
<tr>
<td>_____ Children</td>
<td>_____ Therapists/doctors</td>
</tr>
<tr>
<td>_____ Other relatives</td>
<td>_____ Religious/charitable groups</td>
</tr>
</tbody>
</table>

2. How *willing* are you to seek money, housing, food, or other goods from the following individuals?

<table>
<thead>
<tr>
<th>_____ Spouse/partner</th>
<th>_____ Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Parents</td>
<td>_____ Co-workers/neighbors</td>
</tr>
<tr>
<td>_____ Siblings</td>
<td>_____ Caseworkers/social workers</td>
</tr>
<tr>
<td>_____ Children</td>
<td>_____ Therapists/doctors</td>
</tr>
<tr>
<td>_____ Other relatives</td>
<td>_____ Religious/charitable groups</td>
</tr>
</tbody>
</table>

3. How *willing* are you to seek love, caring, understanding, or reassurance from the following individuals?

<table>
<thead>
<tr>
<th>_____ Spouse/partner</th>
<th>_____ Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Parents</td>
<td>_____ Co-workers/neighbors</td>
</tr>
<tr>
<td>_____ Siblings</td>
<td>_____ Caseworkers/social workers</td>
</tr>
<tr>
<td>_____ Children</td>
<td>_____ Therapists/doctors</td>
</tr>
<tr>
<td>_____ Other relatives</td>
<td>_____ Religious/charitable groups</td>
</tr>
</tbody>
</table>

4. How *willing* are you to tell the details of your problems to the following individuals?

<table>
<thead>
<tr>
<th>_____ Spouse/partner</th>
<th>_____ Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Parents</td>
<td>_____ Co-workers/neighbors</td>
</tr>
<tr>
<td>_____ Siblings</td>
<td>_____ Caseworkers/social workers</td>
</tr>
<tr>
<td>_____ Children</td>
<td>_____ Therapists/doctors</td>
</tr>
<tr>
<td>_____ Other relatives</td>
<td>_____ Religious/charitable groups</td>
</tr>
</tbody>
</table>

5. How *willing* are you to tell your feelings about your problems to the following individuals?

<table>
<thead>
<tr>
<th>_____ Spouse/partner</th>
<th>_____ Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Parents</td>
<td>_____ Co-workers/neighbors</td>
</tr>
<tr>
<td>_____ Siblings</td>
<td>_____ Caseworkers/social workers</td>
</tr>
<tr>
<td>_____ Children</td>
<td>_____ Therapists/doctors</td>
</tr>
<tr>
<td>_____ Other relatives</td>
<td>_____ Religious/charitable groups</td>
</tr>
</tbody>
</table>
6. How willing are you to seek information and advice regarding your problems from the following individuals?

_____ Spouse/partner
_____ Parents
_____ Siblings
_____ Children

_____ Friends
_____ Co-workers/neighbors
_____ Caseworkers/social workers
_____ Therapists/doctors

Difficulties in Emotion Regulation Scale (DERS)

For the following questions, please indicate how often each statement applies to you using the following scale:

1 = almost never (0-10% of the time)
2 = sometimes (11-35% of the time)
3 = about half the time (36-65% of the time)
4 = most of the time (66-90% of the time)
5 = almost always (91-100% of the time)

1. I am clear about my feelings.  
2. I feel at ease with my emotions.  
3. I pay attention to how I feel.  
4. I experience my emotions as overwhelming and out of control.  
5. I have no idea how I am feeling.  
6. I have difficulty making sense out of my feelings.  
7. I am attentive to my feelings.  
8. I know exactly how I am feeling.  
9. I care about what I am feeling.  
10. I am confused about how I feel.  
11. My emotions make me uncomfortable.  
12. When I’m upset, I acknowledge my emotions.  
13. When I’m upset, I allow myself to feel that way.  
14. When I’m upset, I become angry with myself for feeling that way.  
15. When I’m upset, I become embarrassed with myself for feeling that way.  
16. When I’m upset, I have difficulty getting work done.  
17. When I’m upset, I become out of control.  
18. When I’m upset, I become scared and fearful of those feelings.  
19. When I’m upset, I believe that I will remain that way for a long time.  
20. When I’m upset, I believe that I’ll end up feeling very depressed.  
21. When I’m upset, I believe my feelings are valid and important.  
22. When I’m upset, I have difficulty focusing on other things.  
23. When I’m upset, I feel out of control.  
24. When I’m upset, I can still get things done.
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>25. When I’m upset, I feel ashamed with myself for feeling that way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. When I’m upset, I know that I can find a way to eventually feel better</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. When I’m upset, I feel like I am weak.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. When I’m upset, I feel like I can remain in control of my behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. When I’m upset, I feel guilty for feeling that way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. When I’m upset, I have difficulty concentrating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31. When I’m upset, I have difficulty controlling my behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. When I’m upset, I believe there is nothing I can do to make myself feel better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33. When I’m upset, I become irritated with myself for feeling that way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34. When I’m upset, I start to feel very bad about myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35. When I’m upset, I believe that wallowing in it is all I can do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36. When I’m upset, I know there are things I can do to manage my emotions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>37. When I’m upset, I lose control over my behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>38. When I’m upset, I have difficulty thinking about anything else.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>39. When I’m upset, I take time to figure out what I’m really feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40. When I’m upset, it takes me a long time to feel better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. When I’m upset, my emotions feel overwhelming.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Courtauld Emotional Control Scale (CECS)

Below are listed some of the reactions people have to certain feelings or emotions. Read each one and indicate how far it describes the way you generally react using the following scale:

1  2  3  4  
Almost never        Almost always

When I feel angry (very annoyed)...

1. I keep quiet       1  2  3  4
2. I refuse to argue or say anything   1  2  3  4
3. I bottle it up     1  2  3  4
4. I say what I feel  1  2  3  4
5. I avoid making a scene  1  2  3  4
6. I smother my feelings  1  2  3  4
7. I hide my annoyance  1  2  3  4

When I feel unhappy (miserable)...

1. I refuse to say anything about it  1  2  3  4
2. I hide my unhappiness  1  2  3  4
3. I put on a bold face  1  2  3  4
4. I keep quiet  1  2  3  4
5. I let others see how I feel  1  2  3  4
6. I smother my feelings  1  2  3  4
7. I bottle it up  1  2  3  4

When I feel afraid (worried)...

1. I let others see how I feel  1  2  3  4
2. I keep quiet  1  2  3  4
3. I refuse to say anything about it  1  2  3  4
4. I tell others all about it  1  2  3  4
5. I say what I feel  1  2  3  4
6. I bottle it up  1  2  3  4
7. I smother my feelings  1  2  3  4
Silencing the Self Scale (STSS)

Please indicate how much you agree with each statement using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>strongly disagree</td>
<td>strongly agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I tend to put myself first because no one else will.  
2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.  
3. Caring means putting the other person's needs before my own.  
4. Considering my needs to be as important as those of the people I love is selfish.  
5. I find it harder to be myself when I am in a close relationship than when I am on my own.  
6. I tend to judge myself by how I think other people see me.  
7. I feel dissatisfied with myself because I should be able to do all the things other people do.  
8. When my partner's needs and feelings conflict with my own, I always state mine clearly.  
9. In a close relationship, my responsibility is to make the other person happy.  
10. Love means choosing to do what the other person wants, even when I want to do something different.  
11. In order to feel good about myself, I need to feel independent and self-sufficient.  
12. One of the worst things I can do is be selfish.  
13. I feel I have to act a certain way to please my partner.  
15. I say how I feel with my partner, even when it leads to problems or disagreements.  
16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.  
17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.  
18. When my partner's needs or opinions conflict with mine, I usually end up agreeing with him/her.  
19. Whether I am in a close relationship or single, I love who I am.  
20. When it looks as though some of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.  
21. My partner loves and appreciates me for who I am.  
22. Doing things just for myself is selfish.  
23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.  
24. I rarely express my anger at those close to me.  
25. I feel that my partner does not know the real me.  
26. I think it's better to keep my feelings to myself when they conflict with my partner's.  
27. I often feel responsible for other people's feelings.  
28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people feel.  
29. In a close relationship, I don't usually care what we do, as long as the other person is happy.  
30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).  
31. I never seem to measure up to the standards I set for myself.
Eating Expectancies Inventory (EEI)

Read each statement and circle the number of the response which most closely matches your level of agreement. Please respond to the items in terms of what the word “eating” means to you. There are no right or wrong answers. Choose only one response for each item. Do not leave any items blank.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Completely disagree</td>
<td>Mostly disagree</td>
<td>Slightly disagree</td>
<td>Neither Agree nor disagree</td>
<td>Slightly Agree</td>
<td>Mostly Agree</td>
<td>Completely Agree</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td>1. Eating makes me feel loved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. When I am feeling depressed or upset, eating can help me take my mind off my problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. Eating makes me feel out of control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. Eating fills some emotional need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. When I am feeling anxious or tense, eating helps me relax.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. I don’t see eating as a pleasurable event.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. Eating helps me deal with feelings of inadequacy about myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. Eating doesn’t help me deal with boredom.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. When I have nothing to do, eating helps relieve the boredom.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. When I eat, I often feel I am not in charge of my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. When I am feeling anxious, eating does not make me feel calmer.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. Eating serves as an emotional release.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. Eating seems to decrease my level of anxiety if I am feeling tense or stressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. Eating is a good way to celebrate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>15. When I do something good, eating is a way to reward myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. Eating isn’t useful as a reward for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. I don’t get a sense of security or safety from eating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. If I have nothing planned to do during the day, eating isn’t something that would help me fill the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. Eating helps me think and study better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>20. Eating is fun and enjoyable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>21. My eating behavior often results in a feeling that I am not in control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>22. When I work hard or accomplish something, eating doesn’t serve as a good reward.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>23. Eating is something to do when you feel bored.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>24. Eating is a way to vent my anger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>25. Eating helps me avoid uncomfortable social situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>26. When I am angry at my parents, spouse or friends, eating helps me get back at them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>27. When I am faced with difficult tasks, eating can help me avoid doing them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>28. Eating helps me forget or block out negative feelings, like depression, loneliness or fear.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>29. Eating calms me when I am feeling stressed, anxious, or tense.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>30. Eating can help me bury my emotions when I don’t want to feel them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>31. Eating helps me work better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>32. Eating helps me cope with negative emotions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>33. Eating does not make me feel out of control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>34. Eating helps me deal with sadness or emotional pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Eating in Response to Trauma (ERT)

Read each statement and circle the number of the response which most closely matches your level of agreement. Please respond to the items in terms of what the word “eating” means to you. There are no right or wrong answers. Choose only one response for each item. Do not leave any items blank.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I punish myself by eating or avoiding eating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. I can sedate myself by eating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. Eating helps me create structure or predictability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. Eating is a way for me to create psychological space.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. I turn to eating when I want to feel cleaner or more pure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. When I feel like I want to disappear, I can turn to eating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. Eating can be a way to create a smaller or larger body so I can protect</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. Eating helps me deal with negative experiences I’ve had or bad things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. I eat to get away from intrusive thoughts or images.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Emotional Eating Scale (EES)

We all respond to different emotions in different ways. Some types of feelings lead people to experience an urge to eat. Please indicate the extent to which the following feelings lead you to feel an urge to eat by checking the appropriate box.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>No Desire to Eat</th>
<th>A Small Desire to Eat</th>
<th>A Moderate Desire to Eat</th>
<th>A Strong Urge to Eat</th>
<th>An Overwhelming Urge to Eat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resentful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discouraged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaky</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worn Out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rebellious</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jittery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uneasy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jealous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worried</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lonely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furious</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Edge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Binge Eating Scale (BES)

Below are groups of numbered statements. Read all of the statements in each group. Then darken the circle on the IBM sheet that corresponds to the ONE statement in each group that best describes the way you feel about your eating behavior.

1. a. I don’t feel self-conscious about my weight or body size when I’m with others.
   b. I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
   c. I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
   d. I feel very self-conscious about my weight and frequently I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.

2. a. I don’t have any difficulty eating slowly in the proper manner.
   b. Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
   c. At times, I tend to eat quickly and then I feel uncomfortably full afterwards.
   d. I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because I've eaten too much.

3. a. I feel capable to control my eating urges when I want to.
   b. I feel like I have failed to control my eating more than the average person.
   c. I feel utterly helpless when it comes to feeling in control of my eating urges.
   d. Because I feel so helpless about controlling my eating I have become very desperate about trying to get in control.

4. a. I don't have the habit of eating when I'm bored.
   b. I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
   c. I have a regular habit of eating when I'm bored, but occasionally I can use some other activity to get my mind off eating.
   d. I have a strong habit of eating when I'm bored. Nothing seems to break me of the habit.

5. a. I'm usually physically hungry when I eat something.
   b. Occasionally, I eat something on impulse even though I really am not hungry.
   c. I have the regular habit of eating foods that I might not really enjoy to satisfy a hungry feeling even though physically I don't need the food.
   d. Even though I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth hunger. Then I spit the food out so I won't gain weight.

6. a. I don't feel any guilt or self-hate after I overeat.
   b. After I overeat, occasionally I feel guilt or self-hate.
   c. Almost all the time I experience strong guilt or self-hate after I overeat.

7. a. I don't lose total control of my eating when dieting even after periods when I overeat.
   b. Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more.
   c. Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When that happens I eat even more.
   d. I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."
8. a. I rarely eat so much food that I feel uncomfortably stuffed afterwards.
b. Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed.
c. I have regular periods during the month when I eat large amounts of food, either at mealtime or at
snacks.
d. I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit
nauseous.

9. a. My level of caloric intake does not go up very high or go down very low on a regular basis.
b. Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate
for the excess calories I've eaten.
c. I have a regular habit of overeating during the night. It seems that my routine is not to be hungry
in the morning but overeat in the evening.
d. In my adult years, I have had week-long periods where I practically starve myself. This follows
periods when I overeat. It seems I live a life either "feast" or "famine."

10. a. I usually am able to stop eating when I want to.
b. I know when "enough is enough."
c. Every so often, I experience a compulsion to eat which I can't seem to control.
d. Frequently, I experience strong urges to eat which I seem unable to control, but at other times I
can control my eating urges.
e. I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating
voluntarily.

11. a. I don't have any problems stopping eating when I feel full.
b. I usually can stop eating when I feel full but occasionally overeat leaving me feeling
uncomfortably stuffed.
c. I have a problem stopping eating once I start and usually I feel uncomfortably stuffed after I eat a
meal.
d. Because I have a problem not being able to stop eating when I want, I sometimes have to induce
vomiting to relieve my stuffed feeling.

12. a. I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself
b. Sometimes, when I'm with other persons, I don't eat as much as I want to eat because I'm
self-conscious about my eating.
c. Frequently, I eat only a small amount of food when others are present because I'm very
embarrassed about my eating.
d. I feel so ashamed about overeating that I pick times to overeat when I know no one will see me.
I feel like a "closet eater."

13. a. I eat three meals a day with only an occasional between meal snack.
b. I eat 3 meals a day, but I also normally snack between meals.
c. When I am snacking heavily, I get in the habit of skipping regular meals.
d. There are regular periods when I seem to be continually eating, with no planned regular meals.

14. a. I don't think much about trying to control unwanted eating urges.
b. At least some of the time, I feel my thoughts are preoccupied with trying to control my eating
urges.
c. I feel that frequently I spend time thinking about how much I ate or about trying not to eat
anymore.
d. It seems to me that most of my waking hours are preoccupied by thoughts about eating or not
eating. I feel like I'm constantly struggling not to eat.
15. a. I don't think about food a great deal.
    b. I have strong cravings for food but they only last for brief periods of time.
    c. I have days when I can't seem to think about anything else but food.
    d. Most of my days seem to be preoccupied with thoughts about food. I feel like I live to eat.

16. a. I usually know whether or not I'm physically hungry.
    b. I take the right portion of food to satisfy me.
    c. Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times, it's hard to know how much food I should take to satisfy me.
    d. Even though I might know how many calories I should eat, I don't have any ideas what is a "normal" amount of food for me.
## Eating Disorder Diagnostic Scale (EDDS)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you felt fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Have you had a definite fear that you might gain weight or become fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Has your weight influenced how you think about (judge) yourself as a person?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Has your shape influenced how you think about (judge) yourself as a person?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. During the past 6 months have there been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g., a quart of ice cream) given the circumstances?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. During the times when you ate an unusually large amount of food, did you experience a loss of control (feel you couldn't stop eating or control what or how much you were eating)?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. How many DAYS per week on average over the past 6 MONTHS have you eaten an unusually large amount of food and experienced a loss of control? 0 1 2 3 4 5 6 7

8. How many TIMES per week on average over the past 3 MONTHS have you eaten an unusually large amount of food and experienced a loss of control? 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

During these episodes of overeating and loss of control, did you...

9. Eat much more rapidly than normal? YES NO

10. Eat until you felt uncomfortably full? YES NO

11. Eat large amounts of food when you didn't feel physically hungry? YES NO

12. Eat alone because you were embarrassed by how much you were eating? YES NO

13. Feel disgusted with yourself, depressed, or very guilty after overeating? YES NO

14. Feel very upset about your uncontrollable overeating or resulting weight gain? YES NO

15. How many times per week on average over the past 3 months have you made yourself vomit to prevent weight gain or counteract the effects of eating? 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

16. How many times per week on average over the past 3 months have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating? 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

17. How many times per week on average over the past 3 months have you fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating? 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14
18. How many times per week on average over the past 3 months have you engaged in excessive exercise specifically to counteract the effects of overeating episodes?  0  1  2  3  4  5  6  7  8  9  10  11  12  13  14

19. How much do you weigh?  _____ lbs.  (If uncertain, please give your best estimate.)

20. How tall are you?  ____ ft. ______ in.

21. Over the past 3 months, how many menstrual periods have you missed?  1  2  3  4  N/A

22. Have you been taking birth control pills during the past 3 months?  YES NO