TOWARD AN UNDERSTANDING OF RESILIENCE TO DISORDERED EATING AND BODY IMAGE DISSATISFACTION AMONG AFRICAN AMERICAN WOMEN: AN ANALYSIS OF THE ROLES OF ETHNIC AND FEMINIST IDENTITIES

DISSERTATION

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ABSTRACT

Although the research on disordered eating and body image dissatisfaction among European American women is burgeoning, knowledge about eating disorder (ED) symptomatology among African American women is still limited. In order to provide effective treatment and prevention programs, it is imperative to investigate risk and protective factors of ED symptomatology among diverse groups of women. Racist and sexist discrimination have been conceptualized by scholars as putative predictors of disordered eating and body image dissatisfaction, whereas positive cultural and gender identities have been postulated as potential protective factors against ED symptomatology and body image dissatisfaction among African American women. Accordingly, the purpose of the present study was threefold: 1) to examine the relations between racist discrimination, sexist discrimination, ethnic identity, feminist identity, ED symptomatology and body image dissatisfaction; 2) to investigate whether discrimination predicts ED symptomatology and body image dissatisfaction; and 3) to determine whether ethnic and feminist identities moderate (i.e., buffer) the relations between the proposed predictor and criterion variables within a sample (N = 302) of university-affiliated, African American women. The primary hypotheses were as follows: 1) higher levels of discrimination would predict higher levels of ED symptomatology and body image dissatisfaction; 2) higher levels of ethnic identity and feminist identity would
predict lower levels of disordered eating and body image dissatisfaction; and 3) ethnic and feminist identities would individually and collectively moderate the relations between discrimination and ED symptomatology and between discrimination and body image dissatisfaction. As expected, higher levels of ethnogender discrimination significantly predicted higher levels of ED symptomatology. Unexpectedly, higher levels of ethnogender discrimination did not predict higher levels of body image dissatisfaction. As anticipated, higher levels of ethnic identity and feminist identity significantly predicted lower levels of body image dissatisfaction. Unexpectedly, higher levels of ethnic and feminist identity did not predict lower levels of disordered eating. Finally, neither ethnic nor feminist identity was found to moderate the discrimination-ED symptomatology relation or the discrimination-body image dissatisfaction relation. Putative explanations for the aforementioned findings are offered as are implications for research, practice and prevention.
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CHAPTER 1
INTRODUCTION

1.1 Background

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) includes three eating disorders (EDs): Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS). The current criteria for these disorders, however, have been criticized for being too exclusive or too severe. Although the percentages of women meeting criteria for bona-fide clinical eating disorders are small (i.e., .5% for AN, 1-3% for BN, and 2-5% for EDNOS; DSM-IV; American Psychiatric Association, 1994), the incidence of eating disordered behaviors (also referred to as eating disorder symptomatology), particularly among college women, appears to be reaching alarming proportions in Western society (Mintz & Betz, 1988; Tylka & Subich, 2002). Many women who seek treatment for eating disordered behavior do not meet the severity of the criteria required for diagnosis, but still need treatment (Kashubeck-West & Mintz, 2001). Thus, it is critical to understand the incidence and related problems of the full spectrum of eating disorder (ED) symptomatology.

Given the prevalence of eating disordered behavior among college women and the seriousness of such concerns, it is imperative that counseling psychologists be informed
about ED etiology, assessment, and treatment, as these professionals focus on the whole spectrum of disordered eating (Mazzeo & Espelage, 2002). Kashubeck-West and Mintz emphasized this point in their 2001 review in *The Counseling Psychologist* stating that all counseling psychologists should concern themselves with attaining a working knowledge in this area, as they will more than likely be called upon, at some point in their careers, to work with a client with ED symptomatology. Moreover, given that prevalence rates of EDs are particularly high among college women, it is imperative that counseling psychologists in all collegiate arenas (e.g., college counseling centers, faculty, advising) are knowledgeable about eating disorders across diverse groups of women. As college populations, clinical populations, and the U.S. population, as a whole, become increasingly more ethnically diverse, it is crucial that mental health professionals are knowledgeable about how women of diverse ethnic groups are impacted by EDs and ED symptomatology.

1.2 **African American women, disordered eating and body image dissatisfaction**

Although the research on eating disorders among European American women is burgeoning, knowledge about EDs and ED symptomatology and predictors of ED symptomatology (e.g., body image dissatisfaction) among women of color is still limited. Historically, research on body image and eating disorder symptomatology has been based primarily on the experiences of young European American women and has neglected other individuals (Phan & Tylka, 2006). The belief that eating disorders are rare among members of ethnic groups may be attributed, in part, to the fact that treatment centers for eating disorders receive few requests from ethnic minority women (Striegel-Moore & Smolak, 2000). Ethnocentrism, stereotypes, racism, and beliefs that non-western cultural
characteristics (e.g., low perceived pressure for thinness, appreciation of larger body sizes) render women of color invulnerable to body image and eating concerns are additional explanations as to why these women have traditionally been excluded in the eating disorders literature (Root, 1990) and have been assumed to be invulnerable to eating and body image concerns.

Most women living in the United States, or more generally, those who have been exposed to cultural ideals of the Western world, are, indeed, influenced by the thin-ideal stereotype and the extreme focus on body shape. Some scholars (e.g., Root, 1990) contend that ethnic minority women may be especially impacted by Western standards of beauty as their ethnic identification is different from and devalued by the dominant culture. Without a positive ethnic identification, such devaluation may, in turn, lead to increased body image disturbance and disordered eating. It is, therefore, imperative to begin filling the remaining gap in the eating disorders literature regarding predictive and protective factors for women of color (Phan & Tylka, 2006).

1.3 Prevalence among African American women

Scholars have pursued this area of research in recent years and have debunked perceptions that body image and disordered eating are concerns exclusive to European American women (Phan & Tylka, 2006). For example, Lester and Petrie’s (1998) findings revealed that African American college women had levels of bulimic symptomatology similar to those of their Caucasian counterparts. Another study (Cashel, Cunningham, Landeros, Cokley, & Muhammad, 2003) found that even though African American college women reported lower rates of dieting, internalization of the thin ideal,
drive for thinness, and body dissatisfaction than European American women, they were not found to differ on bulimic symptomatology and other correlates (e.g., ineffectiveness, perfectionism, poor interoceptive awareness) of disordered eating.

Similarly, a meta-analysis (Wildes, Emery, & Simons, 2001), which examined the relation between ethnicity and eating disturbance and the specific relation between African American and European American women found that the sample used has salience. Specifically, the results of this meta-analysis indicate that studies using college samples to compare eating disorder symptomatology in African American and European American women find significantly greater differences than other samples. According to the results from the meta-analysis, it appears that African American college women may experience fewer symptoms of eating disturbance and body dissatisfaction than their European American counterparts. It is important to note, however, that this meta-analysis compared African American women to European American women with regard to level of eating disturbance and body image disturbance, and lower levels of disturbance do not indicate absence of symptomatology. Furthermore, African American women included in high school and non-clinic samples were found to evidence levels of eating pathology similar to those reported by their European American counterparts. Specifically, when measures related to clinical symptomatology (e.g., bulimia, general ED symptomatology), dieting, and weight concerns are administered, African American women in non-clinic samples appear to have an equal to greater prevalence than European American women (Wildes et al., 2001).

In contrast to the Wildes et al. (2001) findings regarding college women, Mulholland and Mintz (2001) found that African American college women reported
frequencies of bulimia and anorexia comparable to those of European American samples. This was the only study to date evaluating DSM-IV (American Psychiatric Association, 1994) prevalence rates for eating disorders among African American college students. Similarly, in studies of community samples of African American and European American women comparable levels of eating disturbance have been reported (e.g., Cachelin, Veisal, Barzegarnazari & Striegel-Moore, 2000).

Some studies indicate that the type of eating disorder under investigation may impact findings when comparing ethnic groups. For example, in one meta-analysis (O’Neill, 2003), although European American women in the sample had a slightly greater risk for all eating disturbances combined than did African American women, the effect size was small. Furthermore, African American women did not differ significantly from European American women in their risk for bulimia or binge eating disorder.

The mixed findings of the aforementioned studies seem to underscore the existence of between and within group differences. According to one review (Crago, Shisslak, and Estes, 1996), risk factors for EDs among African American women appear to be greater for women who are younger, heavier, well-educated and more identified with White cultural values. Also, for minority women, being overweight, rather than perceiving oneself as overweight when one is not, appears to be a more significant risk factor for eating disorders and associated symptomatology (e.g., body image disturbance; Crago et al., 1996).

Although the findings have been mixed, some researchers have found ethnic differences in the incidence of eating disordered behavior, as well as in the
behaviors/attitudes that predict such behavior. One variable that has emerged as a central predictor of EDs and ED symptomatology is body image disturbance. Although some studies (e.g., Miller et al., 2000) have found ethnic differences in body image disturbance, indicating a lower rate of body image dissatisfaction among African American university women as compared to European American university women, other studies have found no differences in level of body image disturbance (e.g., Shaw, Ramirez, Trost, Randall, & Stice, 2004) between ethnic groups with adolescent and college women. Moreover, some studies suggest that particular eating disordered behaviors, such as purging, occur more often among African American females than White females (e.g., Field, Colditz, & Peterson, 1997). These findings suggest that risk and protective factors may differ not only for African American women and European American women, but that specific elements of a particular culture may influence the likelihood of developing specific eating disordered behaviors (Striegel-Moore & Smolak, 2000) and body image concerns.

The available research clearly indicates that certain risk and protective factors may differ between and within groups. In order to provide effective treatment and prevention programs for all women who struggle with eating disorder and body image concerns, it is crucial to investigate specific risk and protective factors for individual ethnic groups. The within group differences among African American women regarding ED symptomatology and body image disturbance begs the question: Are there particular attributes that some African American women possess that protect them from ED symptomatology and body image disturbance? The findings that indicate a lower incidence of body image dissatisfaction among some African American women may
indicate, for example, that identifying specifically with African American cultural values or embracing a strong sense of African American identity serves as a protective function against EDs and ED symptomatology. This is an important empirical question that deserves to be addressed.

When examining EDs and ED symptomatology among women of a particular ethnic group, it is important to examine variables that may have particular salience for the group in question. Rather than simply examining predictors and correlates of EDs and ED symptomatology with empirical support among European American women, it is important to consider strengths and challenges that may protect or predict EDs and ED symptomatology among the particular ethnic group under study. Based on the findings in the research literature documenting the deleterious effects of oppression and discrimination on psychological well-being, theorists have speculated that experiences of discrimination may influence the development of ED symptomatology and body image disturbance among African American women (e.g., Gilbert, 2003).

Accordingly, the present study focused on African American women and their experiences with EDs, ED symptomatology, and body dissatisfaction. Furthermore, “ethnic-specific” (i.e., racist events, ethnic identity) and “gender-specific” (i.e., sexist events, feminist identity) experiences and identifications were examined in order to determine whether experiences with particular sociocultural relevance predict and/or protect African American women from ED symptomatology and body image disturbance. Such an investigation is consistent with emerging conceptualizations that challenge the dichotomization of racism and sexism in the lives of African American women (Collins, 1988), and instead emphasize the salience of both forms of discrimination with regard to
psychological health among this group of women. Each form of discrimination will be explored in turn.

1.4 Sociocultural factors and sexism

Women appear to be particularly at risk for disordered eating behaviors, as they make up ninety percent of those suffering from EDs (Striegel-Moore & Cachelin, 2001). In addition to the higher rates of disordered eating among women, researchers (e.g., Dion, Dion & Keelan, 1990; Nolen-Hoeksema & Girgus, 1994; Striegel-Moore & Cachelin, 2001) have also found that a number of psychological disorders including depression and anxiety are more prevalent among women than men. The sociocultural treatment (e.g., sociocultural pressures, sexual objectification, sexism) of women has been proposed as one explanation as to why women more commonly experience symptomatology characteristic of these disorders (Landrine & Klonoff, 1997).

Sexism is a form of discrimination that affects most women at some point in their lives. Klonoff and Landrine (1995) supported this assertion with their findings that 99 percent of college and community-dwelling women reported experiencing sexist events at least once in their lives. Sexist discrimination can take a variety of forms. Klonoff and Landrine (1995) describe incidences of sexist discrimination as sexist events that can range from subtle (e.g., being called sexist names) to more blatant attacks (e.g., sexual harassment) based on an individual’s gender. These instances of discrimination, or sexist events, have been linked to increased psychological distress (e.g., McGrath, Strickland, Keita & Russo, 1990; Woods, Lentz & Mitchell, 1993). For instance, Landrine, Klonoff, Gibbs, Manning, and Lund (1995) found that perceived sexist events accounted for a
greater amount of variance in adult women’s symptoms of anxiety, depression, and somatization than did general stressors (e.g., daily hassles).

With regard to African American women, Klonoff and Landrine (1995) found that ethnic minority college and community women (17% African American women) reported significantly more frequent sexist discrimination in their lifetimes as well as in the past year than did their European American counterparts. These percentages illustrate the prevalence of sexism in society in general, and in the lives of African American women specifically. Furthermore, such findings indicate a need for researchers to continue to investigate the impact that sexist discrimination has on women’s psychological well-being.

Disordered eating has been considered a pertinent form of psychological distress for women, as its clinical (i.e., AN, BN, EDNOS) and subclinical forms (e.g., chronic dieting) forms restrict women by reinforcing their excessive focus on external appearance in lieu of internal attributes such as feelings and intellect (Fredrickson & Roberts, 1997; Sabik & Tylka, 2006). Based on theoretical assumptions and empirical findings that sexist discrimination contributes to psychological distress among women and that ED symptomatology can be conceptualized as a particular form of psychological distress, it would be worthwhile to investigate the relationship between sexist discrimination and ED symptomatology (Sabik & Tylka, 2006).

Although some researchers (Fredrickson, Roberts, Noll, Quinn & Twenge, 1998; Morry & Staska, 2001) have examined the connection between other forms of sexism (e.g., sexual objectification) and disordered eating, only one published study to date has examined the relationship between perceived sexist events and ED symptomatology.
Sabik and Tylka (2006) found that sexist events predicted ED symptomatology among college women based on feminist identity style. The findings of this study highlight the importance of investigating the existence of moderating variables with respect to the sexist events-ED symptomatology relation. Moderators, which can also be considered “protective variables” that alter the strength or direction of the relationship between two variables (Frazier, Tix, & Barron, 2004), can help explain “for whom” sexist events most strongly predicts disordered eating (Sabik & Tylka, 2006) or body image concerns. From a resilience perspective, these moderator variables can be examined as “buffers” for the sexist events-ED symptomatology and sexist events-body image dissatisfaction relations.

Scholars often find it informative to investigate potential moderators when the relationship between two variables is unexpectedly small in size (Frazier et al., 2004). Given that the size of the relationship between sexist events and psychological distress has been small in previous research (e.g., Moradi & Subich, 2002; Swim, Hyers, Cohen, & Ferguson, 2001) the examination of moderators in this context is a useful research endeavor (Sabik & Tylka, 2006). Moreover, it has been recommended that researchers investigate how individual variables interact with sociocultural variables to predict disordered eating and its correlates (e.g., body image dissatisfaction; Striegel-Moore, Silberstein, & Rodin, 1986), as most previous research has primarily focused on variables’ direct contribution to EDs and ED symptomatology (Sabik & Tylka, 2006).

1.5 Feminist identity

Downing and Roush (1985) proposed a model of feminist identity development based on Cross’s (1971) Black identity development model. This model provides a framework for understanding the developmental process in which women engage as they
come to terms with the personal meaning sexism has in their lives (McNamara & Rickard, 1989). The model proposes five stages, which range from the denial of discrimination (i.e., Passive Acceptance), to awareness of sexist discrimination and feelings of anger toward a sexist society (i.e., Revelation), to becoming immersed in women’s cultures and communities (i.e., Embeddedness and Emanation), to the blending of positive attributes of being a woman into the self-concept (i.e., Synthesis), to working toward societal change (i.e., Active Commitment). Although conclusive evidence supporting levels of feminist identity development as “stages” has not yet been garnered, these levels can be conceptualized as feminist identity styles (Sabik & Tylka, 2006).

Scholars have begun to investigate whether particular feminist identity styles may have moderating effects on women’s psychological health. Moradi and Subich (2002), for example, found that high passive acceptance of sexism resulted in a stronger relation between perceived sexist events and overall psychological distress than did low passive acceptance of sexism among a sample of college women. From a resilience perspective, scholars (e.g., Sabik & Tylka, 2006) have also suggested that feminist identity may serve a protective function against psychological distress.

According to Landrine and Klonoff (1997), feminist consciousness provides a cognitive framework for understanding sexism and therefore protects women by decreasing a) their perceptions that sexist events are their own fault and b) the negative impact of these events. Because non-feminist women lack this framework, they misunderstand sexist discrimination as a response to internal characteristics and, in turn, place blame on themselves. In line with the findings that feminist identity moderates that relation between sexist discrimination and other forms of psychological distress, scholars
Sabik and Tylka (2006) tested the assertion that feminist consciousness is a unique personality factor that would moderate the relation between sexist events and ED symptomatology. Their findings indicate that those college women who reject traditional gender roles and embrace a positive feminist identity (i.e., those who were scored high on Synthesis or Active Commitment styles) endorsed fewer symptoms of disordered eating in the face of sexist events than did women who did not embrace a positive feminist identity (i.e., those low on Synthesis and Active Commitment styles). Their findings supported the hypothesis that particular feminist identity styles may act as buffers between sexist events and ED symptomatology. Although the authors found significant ethnic differences in degree of ED symptomatology reported, the interaction between feminist identity style and sexist events accounted for variance above and beyond that accounted for by ethnic group membership (i.e., European American, African American, Asian American, Latina, multiracial, Asian, African; Sabik & Tylka, 2006). These findings underscore the importance of investigating whether feminist identity styles also buffer the relation between sexist events and disordered eating among women of color.

In line with these findings, it seems plausible that feminist identity may moderate the relation between sexist events and body image disturbance, as this variable has been empirically supported as a strong predictor of ED symptomatology. Only one study of which the author is aware investigated whether particular feminist identity styles moderated the relation between sexist events and body image dissatisfaction among African American women. Linnebach (2005) found that one feminist identity style (i.e.,
Synthesis) moderated the relation between recent sexist events and body image
dissatisfaction among African American college women. These findings support extant
theory that sexist events contribute more to the psychological distress of non-feminist
women than of feminist women, and that this theory may extend to African American
women.

Researchers (e.g., Moradi & Subich, 2002) have underscored the importance of
investigating the impact of multiple forms of discrimination on the psychological well-
being of women of color. Although researchers have begun to investigate how feminist
identity impacts disordered eating and body dissatisfaction among college women, racist
discrimination, an equally, or possibly more relevant form of discrimination in the lives
of African American women, must also be investigated within the context of disordered
eating and body image dissatisfaction in order to attend to the full context of African
American women’s lives.

1.6 Racist discrimination

Empirical evidence from numerous studies has indicated that racism continues to
be pervasive in the lives of African Americans (Landrine & Klonoff, 1996). In fact, the
experience of racist discrimination is so rampant that according to the National Institute
of Mental Health (1983), depression, tension, and rage related to the experience of racism
is the single most common struggle presented by African Americans in psychotherapy
(Landrine & Klonoff, 1996). Racism has been defined as a system of oppression based
on racial differences involving cultural messages, institutional policies and practices, and
actions and beliefs of individuals (Tatum, 2000). Ample empirical evidence exists to
support the deleterious effects of racist discrimination on the physical and psychological
health of African American women (see Shorter-Goeden, 2004). For example, King (2003) found that experiences with racist discrimination predicted higher levels of stress and lower state self-esteem among a sample of African American college women. In other studies, researchers (Klonoff & Landrine, 1999; Landrine & Klonoff, 1996) have found positive correlations between the frequency and appraisal (i.e., stress associated with racist events) of racist events with psychological distress among their African American college students and community participants (54%, 53% women, respectively).

In yet another study, Kwate, Valdimarsdottir, Heiddis, Guevarra, and Bovbjerg (2003) found that among African American community women, racist experiences over an individual’s lifetime, as well as in the past year, were related to psychological distress. Moreover, racist experiences in the past year were positively correlated with increased high-risk health behaviors (e.g., increased alcohol and cigarette consumption among drinkers and smokers). Lifetime racist experiences were positively associated with lifetime history of physical disease and negatively correlated with perceived health. Importantly, linear model analyses indicated that these correlations were largely unaccounted for by other variables. Furthermore education level and income were not found to be associated with racist experiences.

In line with these findings, racist events have been conceptualized as a repetitive and reality-based form of trauma in the lives of African American women (Daniel, 2000) which negatively impact both psychological and physical health. As ED symptomatology and body image dissatisfaction are pertinent forms of psychological distress, theorists (e.g., Gilbert, 2003; Mastria, 2002) have suggested that racism may also be linked to disordered eating and its correlates (e.g., body image dissatisfaction).
Thompson (1996) echoed this assertion and proposed that eating problems may begin as a form of coping with various traumas, including racism, sexism, classism, heterosexism, poverty and sexual abuse.

In support of this theory, Talleyrand (2002) found in her community-based sample of African American women that perceptions of racial stressors were directly related to various forms of disordered eating patterns. Specifically, African American women who experienced racist events and perceived them to be stressful reported using compulsive and emotional eating as a means of coping with the psychological stress associated with racist events. Based on these findings, it is essential to continue to investigate the effects of racist events on disordered eating as well as correlates of disordered eating (e.g., body image dissatisfaction). Furthermore, the investigation of potential protective factors of disordered eating and body image disturbance, particularly among women who have traditionally been excluded from this line of research, remains an important area for further study. In addition to feminist identity, theorists and researchers (e.g., Pumariega, Gustavson, Gustavson, et al., 1994) have proposed that a strong sense of ethnic identity may serve a protective function against ED symptomatology and body image dissatisfaction among African American women.

1.7 Ethnic identity

Researchers of the study of ethnicity have underscored the importance of delineating the specific aspects of ethnicity that may contribute to behavior (Phinney, 1996). Accordingly, it is crucial that scholars define and measure what attributes within various groups explain differences among these groups on a variable of interest (e.g., ED symptomatology), rather than simply comparing a particular ethnic group with the
“dominant group” (Striegel-Moore & Smolak, 2000). For example, if the prevalence of eating disorders differs between African American women and European American women, it is important to investigate what specific aspects of being African American may account for these differences (Striegel-Moore & Smolak, 2000). Within the eating disorders literature, studies have often compared ethnic groups to European American groups with respect to symptomatology. Few, however, have explored how ethnic identity and discrimination based on ethnicity affect prevalence rates, symptom expression, clinical course, or treatment of eating disorders (Striegel-Moore & Smolak, 2000).

Ethnic identity has been defined as a multidimensional construct including a commitment and sense of belonging to one’s ethnic group, positive evaluation of one’s group, knowledge of and interest in one’s group, and involvement in traditions and activities of one’s group (Phinney, 1990). Phinney and Chavira (1992) postulated that a low sense of ethnic identity is associated with increased difficulty coping with racism and discrimination which may, ultimately, lead to poor psychological adjustment. Conversely, scholars (e.g., Striegel-Moore & Smolak, 1996) have asserted that a positive ethnic identity is related to an increased ability to cope with racist events and discrimination and, in turn, positive psychological adjustment and self-esteem. Indeed, empirical evidence indicates that a strong sense of ethnic identity leads to greater self-esteem (e.g., Phinney, Cantu, & Kurtz, 1997; Phinney & Chavira, 1992).

In line with such findings, theorists (e.g., Grace, 2002; Striegel-Moore & Smolak, 1996) have postulated that ethnic identity may protect African American women against ED symptomatology and predictors (e.g., body image dissatisfaction, internalization of
the thin-ideal stereotype) of disordered eating. Specifically, some scholars (e.g., Striegel-Moore and Smolak 1996) have hypothesized that identification with African American culture may include internalization of African American standards of attractiveness, which are believed to embrace greater acceptance of diverse body sizes and shapes (e.g., Striegel-Moore and Smolak, 1996). According to such theoretical speculations, it is possible that a strong African American identity may act as a protective factor against ED symptomatology and body image dissatisfaction.

In line with theoretical speculations that a strong sense of ethnic identity may protect African American women from ED symptomatology and body image dissatisfaction, it is important to empirically investigate whether unique strengths (e.g., strong ethnic identity) protect African American women from these concerns. Although some research has indicated that African American women who identify more strongly with White, middle-class values (e.g., Abrams et al., 1993) are at greater risk for ED symptomatology, other studies (e.g., Lester & Petrie, 1998; Pumariega et al., 1994) have refuted these findings suggesting that strong identification with White culture or a strong sense of African American identity is not predictive of ED symptomatology. The findings in this area of research become difficult to interpret, as researchers appear to have conceptualized the construct of ethnic identity in different ways (i.e., the lack of ascribing to White cultural values, identification with African American culture). Accordingly, one of the purposes of the present study will be to investigate whether ethnic identity, as defined by Phinney (1992), protects African American women from ED symptomatology and body image dissatisfaction. More specifically, ethnic identity will be examined to determine whether it buffers the relations between a) racist/sexist
events and ED symptomatology and b) racist/sexist event and body image disturbance among African American women, as no published study to date has investigated these relations in conjunction.

Based on the research which suggests that the experience of stressful life events, in the absence of positive coping, leads to poor psychological adjustment (Phinney & Chavira, 1992) and eating disorder concerns (e.g., Strober, 1984), it is important to investigate what factors may buffer the relation between specific life stressors and ED symptomatology. With respect to African American women, who experience both racist and sexist events, it is crucial to determine which factors may buffer the effects of these stressful life events on ED symptomatology and body image dissatisfaction.

1.8 Summary and objectives

A review of the literature reveals six major points regarding African American women, ED symptomatology, and body image dissatisfaction. First, theorists and researchers have debunked myths that African American women are invulnerable to ED symptomatology and body image concerns. Second, it appears that empirically supported predictors and protective factors of ED symptomatology and body image disturbance for European American women may not be the same factors that predict or protect African American women from ED symptomatology and body image disturbance. These findings underscore the need for further research in this area that focuses specifically on the experiences of African American women. Although the extant eating disorders and body image literatures may be useful in creating hypotheses for African American women, scholars have underscored the significance of considering the unique life context
of African American women when investigating predictive and protective factors of ED symptomatology and body image disturbance among this group of women.

Third, theorists and researchers (e.g., King, 2003; Moradi & Subich, 2003) agree that African American women are in a position of “double jeopardy” or “multiple jeopardy” in which they face discrimination on multiple fronts. Two forms of discrimination (i.e., racism, sexism) have been empirically supported as predictors of a variety of forms of psychological distress including disordered eating among African American women. Racism and sexism have also been postulated to be predictive of body image disturbance among African American women. Researchers (e.g., Moradi & Subich, 2003) have emphasized the value of including both forms of discrimination in research endeavors, as both racism and sexism have explanatory power for psychological distress.

Fourth, scholars (e.g., Pumariega et al., 1994; Sabik & Tylka, 2006) have documented that identification with ethnic and gender identities can serve a protective function against general psychological distress as well as ED symptomatology, specifically. Fifth, preliminary evidence supports positive feminist identity as a moderator (i.e., buffer) of the relation between discrimination and ED symptomatology. Sixth, few studies have examined potential protective factors of ED symptomatology and body image disturbance among African American women. An important question, thus, remains unanswered: why are some African American women resilient to eating and body image disturbance even in the face of multiple forms of discrimination?

Despite calls for research in this area, a dearth of information remains in the literature regarding which variables may buffer the relation between racist and sexist
events and ED symptomatology and body image disturbance among African American women. Accordingly, the purpose of the present study was to attend to this gap, and to identify potential resilience factors of ED symptomatology among African American women. In line with recommendations from researchers (e.g., Moradi & Subich, 2003), the present study investigated the links between racist and sexist events and ED symptomatology. Further, in order to more comprehensively investigate the various types of psychological distress linked to disordered eating, the present study broadened the criteria beyond disordered eating to include body image disturbance, a well documented predictor of disordered eating and an indicator of psychological distress (e.g., Tylka, 2004).

The primary hypotheses were as follows: 1) ethnogender discrimination will predict ED symptomatology and body image dissatisfaction 2) a strong ethnic identity and two positive feminist identity styles (i.e., Active Commitment, Synthesis) will buffer the discrimination-ED symptomatology relation and the discrimination-body image disturbance relation, and 3) feminist and ethnic identity, together will buffer discrimination-ED symptomatology relation and the discrimination-body image disturbance relation.
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Overview

The primary aim of the present study is to identify variables that moderate (i.e., buffer) the relations between racist and sexist discrimination and a) eating disorder (ED) symptomatology b) body image disturbance among African American women. The present chapter reviews the theoretical propositions and empirical findings in the extant literature regarding prevalence of eating disorders and predictors and correlates of ED symptomatology and body image disturbance among African American women. Subsequently, the research regarding putative protective factors will be reviewed. The relationships between the proposed predictors and moderators (i.e., racism, sexism, ethnic identity, feminist identity) and the criterion variables (i.e., ED symptomatology, body esteem) will be explored. A rationale is provided for why ethnic identity and feminist identity may operate as protective mechanisms and, thus, buffer the relations between a) discrimination and ED symptomatology and b) discrimination and body image dissatisfaction. Finally, the chapter concludes with a brief summary and reiteration of the objectives of the present study.
2.2 Prevalence

To date, the empirical data have not provided conclusive evidence with respect to prevalence rates of EDs and ED symptomatology among African American women. The research has also been inconclusive regarding whether African American women are at differential risk for EDs and ED symptomatology when compared to women from other racial/ethnic backgrounds (Striegel-Moore & Smolak, 1996). This is due, primarily, to the fact that the majority of studies have been based on nonrepresentative samples (Striegel-Moore & Smolak, 1996). Nevertheless, studies have documented the existence of ED symptomatology and body image concerns among African American women and have debunked perceptions that such concerns are unique to European American women.

When reviewing the prevalence of eating disorders, it is important to note which particular disorder is being discussed. Therefore, the three eating disorders [Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED)] that have received the majority of empirical attention, with respect to prevalence, will be discussed in turn.

The majority of studies which have investigated the prevalence of AN have indicated that the disorder is rare. However, the incidence of AN among African American women remains unclear, as no study to date has used a large African American sample. The Epidemiological Catchment Area (ECA) study (Robins & Reiger, 1991) involved a representative sample of American adult men and women and reported the point prevalence and lifetime prevalence of AN. The study indicated that AN is rare, occurring in less than 0.5% of the sample. However, no racial comparisons were reported. Another study of 2,163 same-sex, White twins reported similar prevalence rates, lending further support for the rarity of the disorder in the U.S. population.
However, based on the low reported incidence of AN, large samples are necessary to make racial comparisons with respect to AN. Until such studies are completed, the incidence of AN in the African American population will remain unclear.

Until recently, few studies had examined BN symptomatology, specifically, among African American women. Studies which have been completed on the occurrence of bulimic symptomatology among African American women have produced equivocal results. Preliminary studies, which have investigated the presence of bulimic symptomatology using standardized scales of ED symptoms [e.g., Bulimia subscales of the Eating Disorder Inventory (EDI); Garner & Olmsted, 1984; Eating Attitudes Test (EAT); Garner, Olmsted, Bohr, & Garfinkel, 1982] suggest that recurrent binge eating (one criterion of BN) may be as common among African American as it is among Caucasian women (Striegel-Moore & Smolak, 1996). Specifically, studies examining bulimic symptomatology between African American and Caucasian adult women (Wilfley, Schreiber, Pike, Rodin, & Striegel-Moore, 1996; Wing, Adams-Campbell, Marcus, & Janney, 1993) and high school girls (Rosen, Silberg, & Gross, 1988) found no racial differences on the Bulimia subscale of the EDI.

Comparable point prevalence rates of binge eating among African American and Caucasian women have been found in various samples including college students (Gray, Ford, & Kelly, 1987) high school students (Bennett, Splot, & Borgen, 1991) and adult women (Striegel-Moore, Wilfley, Caldwell, Needham, & Brownell, 1996). Lifetime prevalence rates have also been investigated and have produced similar results. For example, one survey (Warheit, Langer, Zimmerman, & Biafora, 1993) yielded results suggesting similar lifetime prevalence rates of binge eating, vomiting, and use of
diuretics as means to control weight among a stratified sample of African American and Caucasian women.

In contrast to findings that suggest similar incidence of bulimic symptomatology among African American and Caucasian women, some studies have indicated that binge eating may be less common among African American college women than Caucasian college women. For example, Abrams, Allen, and Gray (1993) found lower rates of binge eating among African American women than their Caucasian counterparts in their sample of college students. Specifically, 68% of the Caucasian women reported a history of binge eating compared to 42% of the African American women reporting such history. Regarding frequency, 11% of the African American women reported engaging in binge eating once a week in comparison to 21% of the Caucasian women.

Conversely, other studies suggest that the rate of binge eating may, in fact be greater among African American females than Caucasian females. In one study (Chandler, Abood, Lee, Cleveland, & Daly, 1994), which examined eating behaviors among female college students, African American women scored significantly higher on the Bulimia subscale of the EDI than did their Caucasian counterparts. Similarly, Childress, Brewerton, Hodges and Jarrell (1993) investigated binge eating behavior in a sample of 1,610 girls in grades 4 through 8 and found that 5.4% of the Caucasian girls reported binge eating behaviors compared to 11.4% of the African American girls. Finally, in yet another study (Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000), with a community sample of 1,628 African American women and 5,741 European American women, African American women were found to be as likely as European American women to report vomiting or binge eating in the preceding three months, and
were more likely to report abuse of laxatives or diuretics. Moreover, recurrent binge
eating was more common among African American women, suggesting that disordered
eating in general and binge eating specifically is, in fact, a significant concern among
African American women.

In addition to binge eating, researchers have also investigated the use of
purgatives (e.g., diuretics, laxatives) among African American and Caucasian women.
Preliminary evidence suggests that use of purgatives may be more common than
vomiting among African American women when compared to Caucasian women.
Findings from a survey of *Essence* (a popular magazine with primarily African American
readers) readers indicate that the use of laxatives to control weight was more common
(16.5%) than vomiting (3.5%; Pumariega et al., 1994). Another survey of high school
females found that African American girls reported significantly higher rates of diuretic
and laxative use, but reported lower rates of vomiting compared to their Caucasian peers
(Langer, Warheit & Zimmerman, 1991). Although it is difficult to conclusively
determine prevalence rates when different measures of ED symptomatology are used, it is
clear that BN does not solely affect Caucasian women.

Although little is known about the prevalence of BED among African American
women, preliminary evidence suggests that BED may be just as common or even more
common among African American as compared to Caucasian women. One study of
obese participants found BED to be just as common among African American women as
Caucasian women (Yanovski, Nelson, Dubbert, & Spitzer, 1993). Relatedly, field trial
studies investigating the appropriateness of including BED in the DSM-IV (American
Psychiatric Association, 1994) found that non-White participants, most of whom were
African American, enrolled in weight-loss programs were just as likely to fit a diagnosis of BED (22%) as were Caucasian participants (29%; Spitzer et al., 1992; Spitzer et al., 1993). Finally, Marcus (1993) found that requests from African American women to be included in an ongoing treatment trial for obese binge eaters were proportionate to the percentage of African American residents in the area where the trial was being conducted. Further research is needed in order to determine prevalence rates of BED as well as other forms of EDNOS within the African American community.

Some studies (Chandler, Abood, Lee, Cleveland & Daly, 1994; Smith, 1995) have indicated that African American women may be at even greater risk for binge eating behaviors than their European American counterparts. Cashel et al. (2003) contend that these findings are related to a) the fact that African American women tend to be heavier than Caucasian American women and b) the findings that obesity poses a constitutional risk factor for EDs and ED symptomatology, at least among samples of Caucasian women (e.g. Striegel-Moore & Cachelin, 2001). According to these findings, continued research investigating the prevalence and etiology of, and risk and protective factors for EDs and ED symptomatology among African American women, as well as other ethnic minority groups, is imperative in order to develop culturally appropriate treatment and prevention programs.

Based on the aforementioned findings, it is clear that African American women do indeed suffer from EDs and ED symptomatology. Furthermore, it is important to recognize that EDs may not be displayed in identical ways across ethnic groups. For example, African American women may favor the use of purgatives over vomiting or may be more likely to engage in binge eating behavior (as in the case of BN or BED) as
opposed to restricting behavior (as in the case of AN). Accordingly, when investigating EDs and ED symptomatology among African American women, it is important to examine ED symptomatology that is relevant for this particular group. Furthermore, when examining risk and protective factors of EDs it is crucial that researchers consider the possibility that risk and protective factors for African American women may differ from those which have been implicated among samples of Caucasian women.

Studies have suggested that ethnic differences may not only exist with respect to the prevalence of ED symptomatology, but may also exist with respect to the attitudes and behaviors that precede this disordered behavior (Striegel-Moore & Smolak, 2000). For instance, some studies have found that African American women endorse lower rates of body dissatisfaction and dieting behaviors (two empirically supported risk factors for ED symptomatology) compared to their Caucasian counterparts, whereas Hispanic, American Indian, and Asian American females have been found to be either comparable to or more disturbed about their body weight and shape than their Caucasian counterparts (see Striegel-Moore & Smolak, 2000). Other studies suggest that particular eating disordered behaviors, such as purging, occur more frequently among African American, Hispanic and American Indian females than among Caucasian females (e.g., Field, Colditz, & Peterson, 1997).

Taken collectively, these findings suggest that risk and protective factors may differ not only for Caucasian women and ethnic minority women, but that specific elements of a particular culture may influence the likelihood of developing specific eating disordered behaviors (Striegel-Moore & Smolak, 2000). Accordingly, it is important to investigate specific risk and protective factors for individual ethnic groups in order to
better determine appropriate treatment and prevention for each group. The research findings which suggest that African American women experience higher levels of body satisfaction may indicate that identifying specifically with African American cultural values, or having a strong sense of African American identity acts as a protective factor against body image disturbance and, in turn, EDs, and ED symptomatology. This assumption however must be empirically examined.

Based on the limited research findings regarding prevalence of EDs among African American women, it is difficult to make solid conclusions about rates of the individual disorders (i.e., AN, BN, BED, EDNOS). Although preliminary research suggests that AN, for example, may be less common in this population, underrepresentation of African American women in clinic-based samples may result in inaccurate estimates of vulnerability to EDs and ED symptomatology (Striegel-Moore & Smolak, 1996). Furthermore, despite reports that African American women report lower rates of ED-related symptomatology overall, compared to Caucasian American women, the rates of bulimia and anorexia appear to be on the rise among African American women (Weiss, 1995). Accordingly, it is crucial that researchers continue to investigate ED symptomatology among African American women, as well as correlates and predictors of disordered eating that are relevant for this particular group. The following sections will explore potential risk and protective factors of EDs, ED symptomatology, and body image concerns among African American women based on the available research literature.
2.3 **Predictors and correlates of ED symptomatology**

Upon reviewing the research literature in the area of EDs, Striegel-Moore, Silberstein, and Rodin (1986) posed an important question in attempts to integrate and better understand risk factors for EDs. Given the commonality of dieting and weight concerns among women in Western culture, why do only a minority of women develop eating disorders? The authors highlighted several important individual differences among women who experience eating disturbance. They noted that women who develop bulimia, for example, are heterogeneous regarding body weight and eating behavior. Furthermore, a large amount of variance exists among bulimic women regarding the nature and the extent of their psychological disturbance (i.e., some suffer multiple disorders, while others display only ED pathology). Striegel-Moore et al. (1986) proposed that both sociocultural and personal factors contribute to risk in the development of eating disturbance.

When attempting to identify and understand predictors of EDs, the implications of the heterogeneity of this population become clear. It is possible that a particularly strong risk factor for one woman may not necessarily be a risk factor for another, which speaks to the present study. Although certain risk and protective factors for ED symptomatology and correlates of ED symptomatology among African American women may be similar to those of their Caucasian counterparts, others may be quite different as the sociocultural experiences of these two groups of women can be quite different. Accordingly, it is necessary to investigate risk factors that may have particular salience to the African American woman’s experience. The research literature that has used primarily Caucasian samples certainly can be informative with regard to developing hypotheses about eating
disordered behavior among African American women. However, it is also crucial to consider the cultural context of the African American woman’s experience and how this context can both predict and protect women from engaging in disordered eating behavior.

2.3.1 **Body image disturbance**

One variable that has been consistently documented as a central predictor of EDs and ED symptomatology is body image disturbance. In numerous studies (e.g., Cooper & Fairburn, 1993; Garfinkel et al., 1992), White-Caucasian women with eating disorders, compared to normal controls, have consistently reported greater endorsement of three levels of body disturbance: aspirations to a thinner body ideal, greater importance of weight as central to identity, and greater overall weight/body dissatisfaction. In one 2-year prospective study, body image dissatisfaction in young White-Caucasian adolescents predicted later elevations on the EAT-26 (Attie & Brooks-Gunn, 1989). Based on the findings that implicate body dissatisfaction as a risk factor for EDs and ED symptomatology among White-Caucasian women, researchers have begun to investigate the salience of body image dissatisfaction with regard to ED symptomatology among African American women.

Preliminary findings suggest that African American women are less likely to perceive themselves as overweight at the same weight levels as Caucasian women (see Striegel-Moore & Smolak, 1996). Furthermore, despite the findings that indicate a tendency for African American women to be heavier than White-Caucasian women, they appear to experience less social pressure for thinness, an empirically supported risk factor for EDs, ED symptomatology, and body dissatisfaction (see Striegel-Moore & Smolak, 1996). Despite these findings, some studies (e.g., Pumariega et al., 1994; Rosen et al.,
1988, Wilfley et al., 1996) have indicated similar levels of body dissatisfaction among White American and African American women. Why might this be? It appears that weight level may be an important factor. Indeed, when adiposity has been controlled for an interesting picture emerges.

Specifically, some researchers have found that White-American women report greater body image dissatisfaction than African American women as adiposity increases. For example, in one study, Wilfley and colleagues (1996) separated participants into groups based on weight levels (i.e., lowest to highest) and found that although African American and White-Caucasian women reported similar levels of body image dissatisfaction at lowest weight levels, White-Caucasian women at higher weight levels reported significantly greater body image dissatisfaction than did African American women. Based on these findings and others (e.g., Kemper, Sargent, Drane, Valois, & Hussey, 1994; Kumanyika, Wilson, & Guilford-Davenport, 1993), and despite the findings which indicate that African American women tend to be heavier than White-Caucasian women (see Striegel-Moore & Smolak, 1996), it has been suggested that African American women may be more accepting of larger body sizes and may experience higher levels of body satisfaction than their White-Caucasian counterparts at higher weight levels.

The findings which indicate that African American women experience lower levels of body dissatisfaction than White-Caucasian women do not suggest, however, that African American women do not experience body dissatisfaction at all. According to Root (1990) it is imperative that mental health professionals do not assume, based on the findings that African American women embrace larger body sizes, that this group of
women is invulnerable to body image disturbance and ED symptomatology. Furthermore, it is important to underscore the findings from the Wilfley et al. (1996) study regarding body dissatisfaction at lowest weight levels. Although African American women endorsed lower levels of body dissatisfaction at higher weight levels, they endorsed comparable levels of body dissatisfaction at lower weight levels. According to these findings, it is possible that African American women experience body dissatisfaction when they feel “too thin” versus “too large.” It is important that researchers take into account the possibility that body dissatisfaction for different groups may have different meanings.

The inconsistent findings with respect to body image dissatisfaction may be partially explained by an assumption that African American women are dissatisfied with their bodies for the same reasons as their European American counterparts. If, for example, African Americans experience body image dissatisfaction when they feel “too thin” versus “too fat,” then instruments used to measure body image dissatisfaction, which focus on “feeling too large” would not tap this construct accurately for this group of women. In other words, although African American women may not endorse feeling dissatisfied with their bodies based on being too large, they may feel dissatisfied for other reasons (e.g., feeling too thin). If body dissatisfaction is measured with biased instruments (i.e., assuming the thin-ideal is desirable to all women) erroneous assumptions may be made about African American women’s level of body dissatisfaction. Accordingly, researchers may then draw the potentially inaccurate conclusion that African American women are more satisfied with their bodies than European American women.
Although some research (e.g., Abood & Chandler, 1997; Abrams, Allen & Gray, 1993) has indicated that African American women tend to exhibit more positive attitudes toward their bodies than White women, it should not be assumed that all African American women are protected against body image disturbance and eating disordered behavior, as this assumption fails to take within group differences into account (Lester & Petrie, 1998). Furthermore, research has indicated that the relationship between body dissatisfaction and ED symptomatology among African American women may be similar to that of their European American counterparts. Indeed some studies have documented not only the presence of body image dissatisfaction among African American women, but have also found a positive relationship between body image dissatisfaction and ED symptomatology as is the case for European American women.

For instance, studies (e.g., French et al., 1997) have indicated presence of body image dissatisfaction among African American women and have found no ethnic differences with regard to the correlation between body image dissatisfaction and ED symptomatology across diverse ethnic groups. Lester and Petrie (1998) found that body mass, body dissatisfaction and low self-esteem predicted bulimic symptomatology, accounting for 29% of the variance, in their sample of African American college women. Moreover, in this study, African American women reported bulimic symptoms at rates comparable to those found in a primarily European American sample, refuting assumptions that African American women are less prone to bulimic symptomatology.

Additional studies (Mitchell & Mazzeo, 2004; Mulholland & Mintz, 2001) have substantiated these findings demonstrating comparable prevalence rates of ED symptomatology among African American and European American college women.
One recent study (Shaw et al., 2004) examined whether ethnic differences existed in ED symptomatology, risk factors for disordered eating, and relations between risk factors and ED pathology among a sample of African American, Asian, Hispanic, and European American adolescent and adult females. Although African American and Hispanic women reported significantly less internalization of the thin-ideal (a well documented risk factor among Caucasian women) than did Asian Americans or European Americans, no differences were found in mean levels of any of the eating disorder symptoms (i.e., fear of fat, weight/shape concerns, amenorrhea, compensatory behaviors, low BMI or high BMI) or in most eating disorder risk factors (e.g., body dissatisfaction, low self-esteem). Moreover, none of the tests of moderation between risk factors and ED symptomatology differed across ethnic groups. These findings contradict results from earlier studies (e.g., Flynn & Fitzgibbon, 1996; Kemper et al., 1994) which suggest robust ethnic differences in body image and eating disordered behavior. Furthermore, the findings suggest that the risk factors may differ depending on the group studied.

The results from the Shaw et al. (2004) study indicate that diverse ethnic groups may be reaching parity with regard to eating disturbance and body image concerns (Shaw et al., 2004). These findings are consistent with findings from a meta-analysis (Roberts, 2002; see Shaw et al., 2004) indicating that ethnic differences in body dissatisfaction have decreased over the past several decades (Shaw et al., 2004). Another study (Caldwell, Brownell, & Wilfley, 1997) yielded additional support for the notion that African American women experience similar levels of body dissatisfaction to their European American counterparts. This study controlled for BMI, income, and marital
status and found that African American dieters and White women dieters experienced equivalent levels of body dissatisfaction (Caldwell, Brownell, & Wilfley, 1997).

It appears from the research findings that ED symptomatology and body image dissatisfaction may be more common among African American women than was previously assumed (Striegel-Moore & Smolak, 1996). Furthermore, more recent findings suggest that ED symptomatology and body image disturbance among African American women may be on the rise. Whether African American women engage in disordered eating behaviors at the same rate, or experience the same level of body image dissatisfaction as European American women remains unclear. Findings from some of the studies indicate the possibility that risk factors and specific symptomatology for one ethnic group are not necessarily the same for another, which may partially explain the equivocal results. For example, in the Shaw et al. (2004) study, even though African American women experienced lower internalization of the thin-ideal, no differences were found in eating disordered symptoms. This underscores the importance of investigating the possibility of differential risk factors for different groups.

Another possible explanation for the equivocal findings with respect to body image among African American women may be how the construct of body image dissatisfaction has been defined and measured. When investigating the construct of body image disturbance among African American women, it is imperative that researchers consider the unique sociocultural context of African American women’s lives. Historically, research on body image has focused on the thin-ideal stereotype and has emphasized particular areas of the body (e.g., size of hips, buttocks, waist, stomach, legs). Recently, researchers and theorists have underscored the possible salience of
racially defined features with respect to body image among African American women. Body image questionnaires have not considered the possibility that certain parts of the body for racial minority women have been stigmatized and accordingly may be a source of dissatisfaction (Root, 2001). In order to gain a better understanding of body image concerns among African American women, researchers must consider standards of beauty within the context of racial denigration.

Scholars have suggested that race, class, and exposure to a dominant culture which denigrates African American features and physiques may impact body image dissatisfaction among African American women and may, in turn, influence the development of disordered eating patterns (Williamson, 1998). Racially defined features such as the size of the nose, size of lips, color of skin, and texture of hair are physical characteristics that may be relevant to body satisfaction among African American women (Gilbert, 2003; Root, 2001), however traditional measures of body image satisfaction have not included these features (Root, 2001). In accordance with theoretical speculations, Falconer and Neville (2000) found that skin color satisfaction, a racially relevant feature, accounted for a significant amount of the variance among African American women college students in the following three body image dimensions: overall appearance evaluation, satisfaction with specific parts of the body, and internalization of sociocultural messages of appearance. Specifically, greater satisfaction with skin color was related to more positive, internal perspectives of body image (Falconer & Neville, 2000).

It is not the intention of the author to suggest that African American women are not impacted by the thin-ideal stereotype espoused by Western culture. Instead, it is
proposed that within the context of racist discrimination, the sources of body dissatisfaction may also be based on features that have not been traditionally included when measuring this construct. Based on suggestions that African American women may experience body dissatisfaction based on parts of themselves that are devalued and stigmatized by the dominant culture (e.g., Harris, 1994; Harris & Kuba, 1997), it is important that researchers include these features in their assessment of body image dissatisfaction among African American women.

In sum, the research literature clearly indicates the presence of ED symptomatology and body image dissatisfaction among African American women and underscores the importance of investigating differential behavioral symptoms, risk factors, and protective factors of ED symptomatology and its correlates among this traditionally underserved and understudied population. In order to provide effective treatment and prevention programs to a diverse clinical population, it is important to understand both risk and protective factors of ED symptomatology and body image concerns among African American women. One cannot assume that the cumulative risk and protective factors are the same across diverse ethnic/racial groups. According to preliminary research with regard to ED symptomatology and body image concerns among African American women, although some risk and protective factors may be similar to European American women, it appears that others may be different. The present study seeks to address questions raised in the research literature regarding unique factors that may contribute to risk for or protection against body image disturbance and ED symptomatology among African American women.
2.3.2 Degree of overweight

Adiposity has been documented as a central predictor of ED symptomatology and body image dissatisfaction (Striegel-Moore & Smolak, 2000). Furthermore, adiposity has been found to be linked with weight dissatisfaction and a desire for thinness in both European American and African American women (Striegel-Moore & Smolak, 1996). Being overweight is thought to be related to the development of body image concerns due to the experience of feeling different from the cultural beauty ideal, which has clear implications for African American women (Striegel-Moore & Smolak, 2000). Indeed, overweight women are more likely to be subject to criticism and discrimination than are women who have a thinner body type (Striegel-Moore & Smolak, 1996).

Research has consistently shown that African American women are more likely to be overweight than European American women. In fact, four national health surveys have reported that African American women are three times more likely than European American women to fall into the category of obesity (see Striegel-Moore & Smolak, 1996). Furthermore, rates of obesity appear to have increased to a greater degree among African American women than European American women over a 10-year period (Kumanyika, 1987, 1994), which coincides with and may be related to the apparent increase in reports of ED symptomatology and body image disturbance among African American women. Fairburn (1994; see Striegel-Moore & Smolak, 1996) found that obesity in childhood is a risk factor for BN. Furthermore, findings from studies investigating risk factors for BED have indicated that women with the disorder were commonly obese as children (Brody, Walsh & Devlin, 1994).
Numerous studies have implicated adiposity as a significant predictor of body image disturbance in all ethnic groups (Childress et al., 1993; French et al., 1997; Wilfley et al., 1996). Accordingly, obesity may increase risk for disordered eating (e.g., purging) based on its negative effect on body image (Striegel-Moore & Smolak, 1996). Supporting this assertion, studies have found the state of being overweight to be a risk factor for binge eating and purging among African American, Latina, and European American young women (Field, Colditz, & Peterson, 1997). It appears, however, that differences may exist with respect to factors that lead to body dissatisfaction among African American women compared to European American women. When adiposity has been controlled for, some studies have found that White women report greater weight dissatisfaction than do African American women.

As mentioned previously, Wilfley et al. (1996) found that although African American women and White women reported similar levels of body dissatisfaction at the lowest weight level, African American women reported lower levels of body dissatisfaction at the higher weight levels. These findings support other studies (see Striegel-Moore & Smolak, 1996) which indicate a greater acceptance of overweight among African American women. However, they also raise an important question: Are African American more dissatisfied with their bodies when they are underweight? Or perhaps it is the case that African American women simply define body image satisfaction differently than their European American counterparts.

Some authors have asserted that African American women are less pathological and more realistic with respect to body image satisfaction (e.g., Abrams et al., 1993). In support of this assertion, studies (see Striegel-Moore & Smolak, 1996) have indicated
that African American women who experience body dissatisfaction are more likely to actually be overweight, rather than to simply perceive themselves as overweight, as is often the case among European American women. It has also been suggested that African American women have healthier perspectives in general about their bodies and do not necessarily see body shape as central to their identities as individuals (see Striegel-Moore & Smolak, 1996). The manner in which adiposity affects ED symptomatology and body image dissatisfaction among African American women remains unclear. However, it seems plausible that adiposity may, in fact, especially impact African American women with respect to body image and ED symptomatology as they do not match the cultural beauty ideal on two counts. Not only is an African American woman who is overweight different from the dominant cultural beauty ideal based on weight, but she is also different based on race.

Based on differences found in the research literature with respect to adiposity it seems important to include adiposity as a variable of interest when investigating ED symptomatology and body image concerns among this group of women in order to better understand the manner in which variables interact to predict or protect African American women from ED symptomatology and body image disturbance.

2.3.3 Stressful life events/discrimination

Understanding how individuals culturally define and respond to adverse psychological events (e.g., racism, sexism) needs to be considered when investigating the contribution of these events to pathology, in general, and to eating disordered behaviors, specifically (Striegel-Moore & Smolak, 1996). Research suggests that exposure to
stressful life events is related to the onset of eating disorders (Striegel-Moore & Smolak, 1996). Indeed, two studies found that among young girls, those whose transition into middle-school was accompanied by additional stressors (e.g., onset of menarche, onset of dating) were significantly more likely to have elevated scores on the EAT-26 (Garner et al., 1982) than were girls whose transition was not complicated by other stressors (Levine & Smolak, 1992; Smolak, Levine, & Gralen, 1993). Stober (1984) found that the magnitude of life stress experienced by female adolescents diagnosed with AN or BN a year and a half prior to the onset of the disorder was two and half times greater than that of a normative sample of adolescent girls. In addition, a significant correlation was found between magnitude of life stress and severity of binge eating. It appears that interpersonal stressors, specifically, may be particularly likely to lead to binge eating (Strober, 1984).

With respect to African American women and ED symptomatology, stressful life events are of particular relevance. Research indicates that frequency of stressful life events is predictive of psychopathology (Striegel-Moore & Smolak, 1996), and it appears that African American adolescents and adult women experience significantly more stressful life events than their European American counterparts (Newcomb, Huba, & Butler, 1981). One longitudinal study of 2,787 African American adolescent girls supported the assertion that stressful life events predict psychopathology. Specifically, the number of stressful life events was significantly correlated with the degree of psychiatric impairment at one-year follow-up (Brown, Powell, & Earls, 1989).

In addition to the increased number of stressful life events in adolescence, African American adult women are more likely exposed to substandard housing, poverty,
discrimination in the workforce and educational systems, and traumatic life events than are European American women (Striegel-Moore & Smolak, 1996). One major review indicated that greater exposure to stressful life events is associated with differences in psychological health between African American and European individuals (Anderson, 1991). One major life stressor that all African American women face throughout their lives is the oppressive effects of racism.

2.3.3.1 Racism

Upon investigating the eating disorders literature with respect to women of color, it appears that although some variables that influence the prediction or protection of disordered eating may be similar among African American and European American women, other variables may be specific to the sociocultural experience of African American women. Researchers (e.g., Moradi & Subich, 2003) have clearly documented the deleterious effects of racist events on the psychological well-being of people of color, as well the positive impact of strong ethnic identity on psychological adjustment (Phinney, 1992).

Evidence from various studies has indicated that racism continues to be rampant in the lives of African Americans (Landrine & Klonoff, 1996). Specifically, studies have documented discrimination in a number of arenas including health and social services, housing accessibility, employment and interpersonal interactions (Idson & Price, 1992; Krieger, 1990; Landrine, Klonoff, Alcaraz, Scott, & Wilkins, 1995). In fact, the experience of racist discrimination is so prevalent in the lives of African Americans that according to the National Institute of Mental Health (1983), depression, tension, and rage
related to the experience of racism is the single most common struggle presented by African Americans in psychotherapy (Landrine & Klonoff, 1996).

Landrine and Klonoff (1996) assert that racist discrimination takes a multiplicity of forms including being called racist names; being discriminated against by strangers; being accused or suspected of social or criminal wrongdoing (e.g., cheating, stealing); and being discriminated against by various institutions including banks and schools. The authors conceptualize individual forms of racist discrimination as “racist events,” which are considered analogous to generic life stressors (e.g., getting fired, losing keys) as they are specific events that are assumed to be stressful (Landrine & Klonoff, 1996). The authors define racist events as culturally specific, negative life events/stressors that happen to a particular group based on ethnicity or race. In other words these racist events or culturally specific stressors happen to African Americans because they are African American.

Racist events, as compared to generic life stressors (those that can happen to anybody), are considered to be especially stressful as they are inherently degrading and highly personal, attacking something essential about the self that cannot be changed (Landrine & Klonoff, 1996). Accordingly, the authors contend that racist discrimination is a potent source of stress that has a higher potential to have deleterious effects on the physical and mental health of African Americans. Moreover, Landrine and Klonoff (1996) assert that certain personality factors like an Afrocentric social and political consciousness may moderate the negative impact of racist events on the psychological distress among African Americans.
In support of the negative impact of racist events, Landrine and Klonoff (1996) found a positive correlation between the frequency and appraisal (i.e., stress associated with racist events) of racist events with psychological distress among their African American participants (54% women). In a cross-validation of this study, Klonoff and Landrine (1999) found consistent results in a large sample of African American community participants (53% women).

Some researchers have begun to extend this literature to the area of disordered eating and body image and have proposed that racism and discrimination can be conceptualized as traumatic life experiences which may, in turn, predict disordered eating and body image concerns. For example, Thompson (1996) proposed that factors in addition to sociocultural pressure for thinness may lead to disordered eating and body preoccupation, particularly among ethnically diverse women. Specifically, she proposed that eating problems may begin as a means of coping with various traumas, including racism, sexism, classism, heterosexism, poverty, and sexual abuse. Such a theoretical shift with regard to predictors of eating disturbance permits an understanding of the social, political, economic, educational, and cultural resources that women need in order to change their relationship with food and their bodies (Thompson, 1996).

While some research indicates that African American women are less likely than European American to internalize the dominant culture’s thin-ideal stereotype (e.g., Shaw et al., 2004), several scholars (e.g., Gilbert, 2003) have proposed that mainstream culture’s beauty ideals may be especially oppressive for women of color since appearance standards in the U.S. favor European American features, such as skin color, hair texture, and lip size (Harris, 1994). Thus, while African American women may be less likely to
internalize the thin-ideal espoused by Western culture, additional beauty ideals, such as glorification of Eurocentric features, may influence body image disturbance and disordered eating among African American women and other women of color (Gilbert, 2003). Illustrative of this contention is the finding that Afro-Caribbeans who embrace a Eurocentric standard of beauty face a higher risk of developing disordered eating patterns (Thomas & Szmukler, 1985; Hooper & Garner, 1986).

Racism and discrimination may be compounded by having facial features that are not consistent with the dominant culture’s beauty ideals or being heavier than the cultural norm (Thompson, 1994). According to Gilbert (2003), in an effort to “fit in” to the dominant culture, African American women with a lower level of ethnic identity may idealize the dominant culture and its ideals and reject their culture of origin, which may otherwise serve a protective function against eating disordered behavior. Such internalized racism and low levels of ethnic identity may lead to more psychological distress, in general, and ED symptomatology and body image disturbance, in particular (Gilbert, 2003). It is noteworthy that preliminary evidence suggests that those African Americans who endorse and internalize the thin-ideal are more likely than are those who do not internalize this ideal to endorse body image disturbance, disordered eating behaviors and lower self-esteem (e.g., Thompson-Leonardelli, 2003).

Although the experience of racist events has been linked to psychological distress (Moradi, 2002; Moradi & Subich, 2003), and has been proposed as a potential risk factor for body image disturbance and ED symptomatology (Crago, et al., 1996; Thompson, 1996), only one study to date has investigated this relation. Talleyrand (2002) investigated the relation between racial socialization experiences and eating disorder
symptomatology in a community-based sample of African American women. She hypothesized that racial identity schemas would have mediational effects on the relation between perceived racial stressors and coping strategies (i.e., compulsive, emotional or restrictive eating). Her findings suggested that African American women’s perceptions of racial stressors were directly related to various forms disordered eating patterns.

Specifically, African American women who perceived racist events as stressful reported using compulsive and emotional eating as means of coping with the psychological stress associated with racist events. Although no support was found for the hypothesis that racial identity schemas would mediate the relation between racial stressors and disordered eating, racial identity schemas and disordered eating were found to have direct links. Specifically, the Preencounter schema (i.e., lack of awareness of racist events) was significantly, positively related to compulsive and restrictive eating behaviors. In addition, the Immersion/Emersion schema (i.e., immersion into one’s ethnic cultural values; rejection of dominant cultural values) was significantly, positively related to compulsive eating behaviors. Results from this study lend support for the hypotheses that 1) racial and cultural socialization experiences are related to disordered eating behaviors and 2) level of racial identity is related to disordered eating behaviors. These findings indicate a need for investigation of potential moderators of the relation between racist events and ED symptomatology.

In addition to racism, African American women are also exposed to others forms of discrimination. Not only do African American women contend with the deleterious effects of racism in society, they also encounter another form of oppression – sexism. These women, therefore, experience a phenomenon that has been termed “double
jeopardy” (Beal, 1970). The sociocultural context is believed to place African American women in a position where they are not only devalued by the dominant culture based on their race, but are also devalued based on their gender.

2.3.3.2 Sexism

It has been well documented in the empirical literature that women are particularly at risk for disordered eating behaviors and body image concerns. Indeed, women make up ninety percent of those suffering from EDs (Striegel-Moore, Silberstein, & Rodin, 1986; Striegel-Moore & Cachelin, 2001). In addition to the higher rates of disordered eating among women, researchers (e.g., Dion, Dion & Keelan, 1990; Nolen-Hoeksema & Girgus, 1994; Striegel-Moore & Cachelin, 2001) have also found that a number of psychological disorders including depression and anxiety are more prevalent among women than men. The sociocultural treatment (e.g., sociocultural pressure for thinness, sexual objectification, sexist discrimination) of women has been postulated as one explanation as to why women more commonly experience symptomatology characteristic of these disorders (Landrine & Klonoff, 1997).

Specifically, women are often devalued and face sexual objectification and discrimination in their interactions with employers, teachers, professors, acquaintances, service workers, family members, and partners. Klonoff and Landrine (1995) conceptualized these instances of discrimination as sexist events, which they defined as negative stressors exerted upon women specifically because they are women. Based on the empirical support that has been garnered for the connection between environmental stress and psychological distress (e.g., McGrath, Strickland, Keita & Russo, 1990; Woods, Lentz & Mitchell, 1993), it is possible that sexist events explain, in part, why
women report greater symptomatology for some psychological disorders than men. Moreover, the experience of sexist events is believed to have an even greater negative impact on women’s mental and physical health than general life stressors, as this experience is highly personal and represents an attack on an essential quality of the self that cannot be changed (Landrine & Klonoff, 1997).

Sexist events against women have been described as behaviors ranging from subtle attacks, such as being treated with lack of respect due to one’s gender or being called sexist names, to attacks that are more blatant, such as sexual harassment, physical abuse, sexual assault or rape (Landrine & Klonoff, 1997). Empirical evidence exists to support the assertion that subtle sexist attacks are pervasive and intertwined within women’s lives (Sabik & Tylka, 2006). For example, Klonoff and Landrine (1995) found that 99 percent of college and community-dwelling women reported experiencing sexist events at least once in their lives. A majority of these women reported being forced to listen to sexist jokes (94.1%), treated with a lack of respect (82.7%), called sexist names (82.2%), sexually harassed (82%), discriminated against by service workers (75.7%) and strangers (73.2%), and physically threatened (56.4%).

With regard to African American women, Klonoff and Landrine (1995) found that ethnic minority women (17% African American women) reported significantly more frequent sexist discrimination in their lifetimes as well as in the past year than did their European American counterparts. These percentages illustrate the prevalence of sexism in society in general, and in the lives of African American women specifically. Furthermore, such findings indicate a need for researchers to investigate the impact that sexist discrimination has on women’s psychological well-being.
Recently, researchers have heeded this call and have found support for the link between subtle forms of sexist events and women’s psychological health. For instance, Landrine, Klonoff, Gibbs, Manning, and Lund (1995) found that perceived sexist events accounted for a greater amount of variance in adult women’s symptoms of anxiety, depression, and somatization than did general stressors (e.g., daily hassles). Furthermore, separate regression analyses for women of color were completed and indicated that although lifetime sexist events accounted for only 3% of the variance in psychological distress among European American women, lifetime sexist events accounted for 30% of the variance in psychological distress among women of color.

In a replication and extension of this study, Landrine and Klonoff (1997) investigated the relation between perceived sexist events and psychological distress in a sample of community women (36% ethnic minority women of which 17% were African American) and completed separate stepwise regression analyses for ethnic minority women and European American women. They found that in every regression the “best predictor(s)” accounted for more variance in symptoms of psychological distress for ethnic minority women than for European American women, which suggests differential effects of sexism for diverse groups of women (Moradi & Subich, 2003) and highlights the importance of investigating the unique effects of sexist discrimination on ethnic minority women. More specifically, these results seem to suggest that sexist events may have an especially harmful effect on the psychological well-being of women of color.

Swim, Hyers, Cohen, and Ferguson (2001) also investigated the relation between women’s perceived sexist events and psychological distress by conducting diary studies. Specifically, college women recorded incidents that they observed involving themselves,
someone else, or women in general being treated differently due to their gender, and then recorded their emotional reactions to each incident over a two-week period. On average, women logged two incidents within this period. In response to these incidents, they stated that they felt very angry or upset. Additionally, Swim and colleagues (2001) reported that the number of reported sexist events predicted psychological distress among college women, even after controlling for negative affect, state self-esteem, feminist beliefs, and feeling threatened by the possibility of being stereotyped. In another study, Moradi and Subich (2002) found that perceived sexist events were related to college women’s levels of psychological distress after controlling for age, socio-economic status, and social desirability.

Another study (Moradi & Subich, 2003) investigated the relationship between both sexism and racism and psychological distress among a sample of African American college students and community members. The authors found that a) racist and sexist events were significantly correlated and b) sexist events accounted for unique variance in psychological distress among their sample of African American women.

Conversely, Corning (2002) obtained mixed results in her study investigating the relation between perceived sexist events and psychological distress within two samples of predominantly European American college women. Although her first study did not yield empirical support for this relation, results from her second study indicated that perceived sexist discrimination was related to depression and somatization, but not to anxiety. Furthermore, the significant relations were small in size, indicating that perceived sexist discrimination accounted for only a small percentage of the variance in psychological distress (i.e., depression, somatization).
Interestingly, upon closer examination of the collective results obtained by Corning (2002), Landrine et al. (1995), Moradi and Subich (2002), and Swim et al. (2001), sexist events accounted for only a small percentage of the variance in women’s symptomatology (Sabik & Tylka, 2006). According to Frazier, Tix and Barron (2004), when an unexpectedly small relation is found between two variables, it is informative to examine whether third variables may be operating as moderators of this relation.

Exploring moderating variables is especially informative when investigating experiences of subtle sexist discrimination that occurs through women’s lifetimes, as such experiences are proposed to be distal predictors of psychological distress (i.e., those which may lay the foundation for manifestation of distress but do not directly predict this distress; Landrine et al., 1995). Such pervasive, subtle experiences of sexist discrimination distinguish themselves from more recent, blatant sexist events, which are believed to be proximal predictors of women’s psychological distress (Sabik & Tylka, 2006).

Based on this line of reasoning, Corning (2002) sought to empirically investigate whether one personal variable (i.e., self-esteem) would moderate the relation between perceived sexist discrimination and symptoms of depression, anxiety, and somatization. In her first sample of women, she found that although perceived sexist discrimination was not directly related to any of the forms of psychological distress measured, personal self-esteem moderated the relation between perceived sexist discrimination and depression. Specifically, for those women with low levels of personal self-esteem, depression increased with perceived sexist discrimination. However, as personal self-esteem increased, the effect of perceived sexist discrimination on depression decreased.
In her second sample, direct relations were found between perceived sexist discrimination and both depression and somatization. Additionally, data yielded significant interaction effects for collective self-esteem (i.e., the extent to which an individual identifies with and positively evaluates her social groups) across the measures psychological distress (i.e., depression, anxiety, somatization). Specifically, for women with low levels of collective self-esteem, psychological distress increased as perception of sexist discrimination increased. As collective self-esteem increased, the relation between perceived sexist discrimination and these forms of psychological distress decreased.

These findings have important implications for the present study. As collective self-esteem was defined by the author as the extent to which an individual identifies with and positively evaluates her social groups, and collective self-esteem was found to moderate the sexist discrimination-psychological distress relation, it seems plausible that feminist identity and/or ethnic identity may moderate the relations under investigation in the present study (i.e., sexist events-ED symptomatology, sexist events-body esteem, racist events-ED symptomatology, racist events-body esteem). Moreover, the present study represents an important extension of these findings to African American women.

Extending Corning’s (2002) work, Moradi and Subich (2004) explored whether personal self-esteem moderated the relation between women’s perceived sexist events and their overall psychological distress. Indeed, these researchers found that personal self-esteem moderated this relation. Specifically, perceived sexist events was related to overall psychological distress for participants with low personal self-esteem, but not for participants with high personal self-esteem. These findings indicate the presence of
intrapersonal variables that interact with sexist discrimination to predict psychological distress.

Accordingly, one of the primary aims of the present study is to investigate whether particular intrapersonal variables (e.g., feminist identity) interact with sexist events to predict ED symptomatology and body image disturbance among African American women. In other words, perhaps there are internal attributes among African American women that protect them against ED symptomatology and body image disturbance in the face of sexist discrimination. Furthermore, as it can be safely assumed that all African American women have experienced racist events periodically throughout their lives, and only some go on to experience disordered eating behaviors and body image concerns, an important question remains unaddressed. What factors may buffer the relations between a) sexist/racist discrimination and ED symptomatology and b) sexist/racist discrimination and body image dissatisfaction among African American women? In other words, what factors protect African American women from body image disturbance and ED symptomatology even in the face of racist and sexist discrimination which devalues core parts of themselves?

2.4 Protective factors

Although a protective factor can be conceptualized as the opposite pole of a risk factor (e.g. if low self-esteem is a risk factor, then high self-esteem may be thought of as a general protective factor), research on other mental disorders has demonstrated that the “flip-side” of a risk factor does not necessarily constitute a protective factor (Striegel-Moore & Cachelin, 1999). While difficulty in peer relationships, for example, has been documented as a risk factor for adolescent depression, positive peer
relationships do not appear to contribute to resilience against adolescent depression (See Striegel-Moore & Cachelin, 1999). Based on these research findings, and in line with the values of counseling psychology, theorists in the area of EDs (e.g., Striegel-Moore & Cachelin, 1999) have urged researchers to empirically investigate positive characteristics that may operate as protective mechanisms against ED symptomatology.

Scholars have addressed the issue that not all women who encounter identified risk factors develop ED symptomatology (e.g. Stice, 1994). For example, while studies have shown that a large percentage of women experience sociocultural pressures for thinness (e.g., Twamley & Davis, 1999; Striegel-Moore & Cachelin, 2001), a relatively small proportion of these women develop high levels of ED symptomatology (Striegel-Moore & Cachelin, 2001). Of relevance to the present study is the notion that although one can assume that any given African American woman has experienced some form of both racism and sexism in her lifetime, not all African American women go on to experience ED symptomatology and/or body image disturbance. A logical question then emerges regarding these relationships; what positive characteristics may moderate (i.e. buffer) relationships between putative predictors (e.g., racism, sexism) of ED symptomatology and body image disturbance and the criterion variables themselves (i.e., ED symptomatology, body image disturbance)? In order to better understand what makes some African American women resilient to ED symptomatology and body image disturbance, it is necessary to empirically investigate potential moderators of this relation. Two potential moderators of the racist/sexist discrimination-ED symptomatology and racist/sexist discrimination-body image disturbance relations are ethnic identity and feminist identity.
2.4.1 Feminist identity

Feminist identity has been conceptualized within a developmental model proposed by Downing and Roush (1985). Their multidimensional model involves five stages of feminist identity development. The first stage, Passive Acceptance, involves acceptance of traditional gender roles, the belief these roles are advantageous, and the belief that men are superior to women. The second stage, Revelation, reflects questioning of traditional gender roles, feelings of guilt for previous participation in sexism, anger directed at men, and dualistic thinking. The third stage, Embeddedness-Emanation, is characterized by feelings of and a desire for connectedness with other women and cautious interactions with men. The fourth stage, Synthesis, reflects a positive self-concept characterized by positive attributions related to being a woman, ability to transcend traditional gender roles, and an evaluation of men on an individual basis. The fifth and final stage, Active Commitment, reflects a woman’s commitment to social change and the belief that men are equal to, but not the same as women (Sabik & Tylka, 2006).

Researchers have begun to investigate the putative relationships between feminist identity development and body image and disordered eating concerns. The findings have produced equivocal results. For example, Cash, Ancis, and Strachan (1997) examined feminist identity development and gender/body image attitudes in a sample of college women. The expectations were that women in the Passive Acceptance stage would endorse stereotypic attitudes about female body image (Moradi, Subich, & Phillips, 2002) whereas women in the more advanced stages (e.g., Synthesis, Active Commitment) would endorse less stereotypic attitudes about body image. Surprisingly, only two of the
24 correlations between feminist identity development and body image attitudes were significant, and were of relatively low magnitude (Moradi, et al., 2002).

Conversely, Snyder and Hasbrouck (1996) investigated feminist identity development, gender role attitudes and correlates of disordered eating and found significant relations between feminist identity stages and correlates of body image and disordered eating. The significant findings supported Downing and Roush’s (1985) feminist identity development theory indicating a link between higher Passive Acceptance scores and the following variables: a greater desire to be thinner, a greater perception of the ideal body shape/size as thinner than one’s perceived silhouette, and greater overall body dissatisfaction.

In addition, Active Commitment and Synthesis scores were found to correlate with ED symptomatology in the expected direction. Specifically, Active Commitment scores correlated negatively with the Eating Disorder Inventory’s (EDI; Garner, Olmstead, & Polivy, 1983) Drive for Thinness scale and Synthesis scores were found to correlate negatively with Bulimia and Personal Ineffectiveness scales of the EDI. These findings support Downing and Roush’s conceptualization that Synthesis and Active Commitment attitudes reflect more positive and sex-role transcendent feminist identity attitudes (Moradi, Subich, & Phillips, 2002) and that such attitudes are inversely related to body image and disordered eating concerns. The mixed findings, however, indicate a need for further clarification regarding how feminist identity styles impact body image and eating disorder concerns among women, and more specifically, among diverse groups of women.
Based on the proposed link between sexist events and feminist identity, researchers have begun to investigate women’s level of feminist identity as a moderator of the relation between perceived sexist events and psychological distress. For example, in their 2002 study, Moradi and Subich conceptualized feminist identity in accordance with Downing and Roush’s (1985) model and found that high passive acceptance of sexism resulted in a stronger relation between perceived sexist events and overall psychological distress than did low passive acceptance of sexism. Their findings suggest that feminist identity styles may either strengthen or buffer, depending on the feminist identity style considered (e.g., Passive Acceptance vs. Active Commitment), the relation between sexist events and psychological distress. An important extension of these findings would be to investigate the relationship between sexist events and more specific forms of psychological distress among African American women in particular, as the Moradi and Subich (2002) sample was predominantly European American. A logical extension of these findings would be to investigate particular forms of psychological distress that are relevant in the lives of women, such as ED symptomatology and body image concerns.

Although a large body of literature has documented how sociocultural factors (e.g., sociocultural pressure for thinness) and personal factors (e.g., low self-esteem, body dissatisfaction, negative affect) contribute to risk for developing ED symptomatology, researchers have just begun to investigate how sexism, specifically, impacts disordered eating among women. For example, some scholars (e.g., Fredrickson, Roberts, Noll, Quinn & Twenge, 1998; Morry & Staska, 2001) have investigated the connection between particular forms of sexism (e.g., sexual objectification) and disordered eating
and/or correlates of disordered eating (e.g., self-esteem, body surveillance, body shame).

Disordered eating is a pertinent form of psychological and physical distress for women, as its clinical forms (i.e., anorexia, bulimia, eating disorder not otherwise specified), as well as its subclinical forms (e.g., chronic dieting) confine women by reinforcing their focus on external appearance in lieu of internal qualities such as their feelings and intellect (Fredrickson & Roberts, 1997). Moreover, disordered eating unduly affects women, as approximately 90 percent of those with bulimia and anorexia nervosa are women (Striegel-Moore & Cachelin, 2001). Curiously, only one published study to date (Sabik & Tylka, 2006) has explored the relation between perceived sexist events, as defined by Landrine and Klonoff (1997), and disordered eating.

Sabik and Tylka (2006) explored the relation between perceived sexist events and disordered eating behaviors and attitudes. More specifically, the authors tested the assertion that feminist consciousness is a unique personality factor that weakens the relation between sexist events and psychological distress and strengthens the relation between sexist events and psychological well-being (Landrine & Klonoff, 1997). In other words, it was the authors’ contention that a high level of feminist consciousness would buffer the relation between perceived sexist discrimination and ED symptomatology (i.e., protect women from disordered eating even in the face of sexist discrimination).

According to Landrine and Klonoff’s theory (1997) feminist consciousness provides a cognitive framework for understanding sexism and therefore protects women by decreasing a) their perceptions that sexist events are their own fault and b) the negative impact of these events (e.g., psychological distress). Because non-feminist
women lack this framework, they putatively misunderstand sexist discrimination as a response to personal characteristics and, in turn, place blame on themselves. In support of this theory, Klonis, Endo, Crosby, and Worell (1997) investigated the impact of sexist discrimination and found that 81% of their participants used feminist identification as a means of coping with discrimination in their lives. In other studies, feminist identity styles have been found to be related to perceived sexist events (e.g., Fischer et al., 2000; Moradi & Subich, 2002). According to these findings, it is possible that feminist attitudes may help women recognize and label sexist events appropriately, which may, in turn, protect them from the deleterious effects of these events.

In line with this theory, Sabik and Tylka (2006) sought to determine whether feminist identity styles would moderate (i.e., buffer) the relationship between sexist events and eating disordered behavior, a particular form of psychological distress. They proposed that women with high levels of feminist consciousness would be protected against disordered eating; as women high on feminist consciousness would be less likely assume personal responsibility for their experiences with sexist discrimination. Conversely, those women low on feminist consciousness would likely internalize blame for sexist discrimination and would, in turn, not be protected against disordered eating.

This assertion has been partially addressed in the eating disorders literature. For example, Guille and Chrisler (1999) found that a greater acceptance of traditional gender roles correlated positively with compulsive eating among a sample of adult women. In another study, identification with feminist values was negatively related to bulimic symptomatology among a sample of college women (Snyder & Hasbrouck, 1996). These findings indicate that feminist attitudes may protect women against disordered eating.
According to these findings, Sabik and Tylka (2006) theorized that women low in feminist consciousness may be more likely to perceive sexist discrimination as their fault and, in turn, channel the distress experienced from discrimination onto their bodies in the form of disordered eating. Along these same lines, women high in feminist consciousness would be less likely to assume personal blame for sexist events, thus appropriately contextualizing sexism. In turn, these women would be less likely to engage in disordered eating behaviors (Sabik & Tylka, 2006).

Various methods for operationalizing feminist consciousness exist within research (Moradi, Subich, & Phillips, 2002). Sabik and Tylka (2006) defined feminist consciousness in line with researchers’ recommendations (e.g., Moradi & Subich, 2002) and in accordance to Downing and Roush’s (1985) theoretical conceptualization of feminist identity. It is important to note that no empirical evidence has been garnered that supports this as a stage/developmental model. Sabik and Tylka (2006) therefore conceptualized these levels of feminist identity development as feminist identity styles.

The authors hypothesized that those women who accept traditional gender roles (i.e., high passive acceptance) may experience greater levels of ED symptomatology related to their experience of sexist events than would women who do not accept these traditional roles (i.e., low passive acceptance). Furthermore, they hypothesized that high levels of Synthesis and Active Commitment, which are thought to represent positive feminist identity styles, would buffer the relation between sexist events and ED symptomatology.

Sabik and Tylka’s (2006) findings supported extant theory that sexist events contribute more to the psychological distress of non-feminist women than of feminist
women. Specifically, for women low on Synthesis and Active Commitment to a feminist identity, perceived lifetime and recent sexist events positively predicted disordered eating. Conversely, for women high on Synthesis and Active Commitment, sexist events did not predict disordered eating. These findings support the moderator hypothesis that a high level of feminist identity would buffer the relation between sexist events and ED symptomatology.

Of relevance to the present study are the findings indicating that although significant differences in ED symptomatology based on ethnicity emerged, no significant differences were found in reports of sexist events. Furthermore, the significant interactions accounted for variance in disordered eating beyond the variance accounted for by ethnic group membership. According to the authors, an important next step in extending the literature would be to examine the relations between sexist discrimination, feminist identity styles, and ED symptomatology among women of color. Furthermore, based on the significant numbers of women who report body image disturbance (Mazzeo, 1999) and the strong links between body image disturbance and ED symptomatology, the authors recommend investigating whether feminist identity styles interact with sexist discrimination in predicting body image dissatisfaction.

Only one study could be located that examined the relationship between sexist events and body image dissatisfaction. Linnebach (2005) investigated whether feminist identity styles moderated the relation between perceived sexist events and body image dissatisfaction among European American and African American college women. Her findings indicated that although feminist identity did not moderate this relationship among European American women, one feminist identity style (i.e., Synthesis)
moderated the relation among African American women. Specifically, those African American women who endorsed high levels of Synthesis in the face of sexist events appeared to be protected (i.e., buffered) against body image dissatisfaction.

It is important to note that recent theoretical innovations have emerged with regard to the conceptualization of women’s identity development for diverse groups of women. Helms (cited in Ossana, Helms, & Leonard, 1992) introduced a model of Womanist Identity Development which focuses on women’s self-definition as women rather than feminists and underscores the process of self-definition as women (Moradi, Subich, & Phillips, 2002). Helms asserts that this process of womanist identity development is similar across race, social class, and political orientation and does not assume that adoption of a political feminist identity is necessary for healthy identity development to take place (Moradi, et al., 2002). Some scholars (e.g., Boisnier, 2003) have argued that womanist identity development may more aptly describe the process of gender identity development among African American women, as it does not assume an adoption of feminist attitudes. Moradi et al. (2002) draw a distinction between the two models of gender identity development and assert that the womanist model focuses on the locus of self-definition as a woman whereas the feminist model integrates the awareness of the oppression women experience into one’s identity. Theorists have also speculated that the two models may overlap with regard to their definitions of gender identity development; however there is a lack of empirical data that supports such an assumption (see Moradi et al., 2002).

Although it would be useful to examine womanist identity development in conjunction with feminist identity development based on speculations that womanist
attitudes may be more relevant to the experiences of African American, such endeavors are limited by the lack of instruments with strong psychometric properties that measure this construct. The Womanist Identity Attitudes Scale (WIAS; Ossana et al., 1992), which is currently the only published measure of womanist identity, has been found to have extremely low internal consistency reliabilities by a number of researchers and has not yielded crucial validity data (see Moradi et al., 2002). Based on the conceptualization of feminist identity as inclusive of oppressive experiences into one’s identity and the data supporting the psychometric strength of instruments measuring this construct, the present study will examine feminist identity in combination with ethnic identity in order to attend to the salience of multiple identities in the lives of African American women.

With the exception of the studies mentioned herein, few other studies to date have investigated protective factors of ED symptomatology and its correlates (Rubin, Nemeroff, & Russo, 2004; Striegel-Moore & Cachelin, 1999). Moreover, despite repeated calls from researchers and theorists, there remains a dearth of information in the literature regarding specific risk and protective factors of ED symptomatology and body image disturbance among women of color. In line with the aforementioned findings, the intent of the present study is to investigate whether a strong positive identification with an individual’s multiple identities may buffer the relation between stressful life events (i.e., racism, sexism) specific to the African American woman’s sociocultural experience and two specific forms of psychological distress (i.e., ED symptomatology, body image disturbance). Another personality variability that has been proposed as a protective factor against psychological distress among African American women is a strong identification with one’s ethnic group.
2.4.2 **Ethnic identity**

Ethnic identity has been defined as a multidimensional construct including a commitment and sense of belonging to one’s ethnic group, positive evaluation of one’s group, knowledge of and interest in one’s group, and involvement in traditions and activities of one’s group (Phinney, 1990). According to Phinney (1996), ethnicity includes cultural values, behaviors, attitudes, a sense of group membership, and experiences with minority status. Related to a strong ethnic identity is a rejection of racial stereotypes propagated by mainstream culture (Striegel-Moore & Smolak, 1996).

Phinney and Chavira (1992) postulated that a low sense of ethnic identity is associated with difficulty coping with racism and discrimination which may, ultimately, lead to poor psychological adjustment. Conversely, those individuals who identify more strongly with their ethnic group may be better equipped to cope with racist events and discrimination and, in turn, maintain positive adjustment and self-esteem. Empirical evidence has indicated that a strong affiliation with one’s ethnic group (i.e., ethnic identity) leads to greater self-esteem (e.g., Phinney, 1991; Phinney & Chavira, 1992; Spencer & Markstrom-Adams, 1990; St. Louis & Liem, 2005) and lower levels of depression (St. Louis & Liem, 2005).

In the case of eating disordered behavior, ethnic identity has been theorized (e.g., Striegel-Moore & Smolak, 1996) to protect African American women against ED symptomatology and predictors (e.g., body image disturbance, endorsement and internalization of the thin-ideal stereotype) of disordered eating (e.g., Grace, 2002). With regard to eating concerns and African American culture, specifically, Striegel-Moore and
Smolak (1996) postulate that identification with African American culture may include internalization of African American standards of attractiveness. It has been proposed that these standards may reflect a greater acceptance of diverse body sizes and shapes (Striegel-Moore & Smolak, 1996). Accordingly, it is possible that identification with the African American culture acts as a protective factor against ED symptomatology and its correlates (e.g., body image disturbance) among African American women.

In support of this assertion, findings from various studies (e.g., Abrams et al., 1993; Harris, 1995; Pumarega et al., 1994) indicate that African American women who identify strongly with White culture exhibit a greater number of eating disordered concerns such as fear of fat and dietary restraint than do African American women who identify more strongly with African American culture. These findings suggest that ascribing to White cultural values may act as a risk factor for ED symptomatology among African American women. In line with these findings, it is plausible, then, that a strong identification with African American culture may act as a protective factor against ED symptomatology and body image disturbance.

Based on theoretical speculations that ethnic identity may protect African American women against disordered eating patterns, it is important to empirically investigate whether unique strengths (e.g., strong ethnic identity) protect African American women from disordered eating behavior and body image disturbance. Although some research has indicated that African American women who identify more strongly with White, middle-class values (Abrams et al., 1993; Hsu, 1987; Osvold & Sodowsky, 1993; Pate, Pumariega, Hester, & Garner, 1992; Rucker & Cash, 1992; Silber, 1986) are at greater risk for ED symptomatology, other studies (e.g., Lester & Petrie,
1998; Pumariega et al., 1994) have refuted these findings suggesting that strong identification with White culture is not predictive of ED symptomatology.

It is difficult to determine, based on the research findings, whether cultural identification is predictive of ED symptomatology, as researchers conceptualize this construct in different ways. Some researchers (e.g., Abrams et al., 1993) have examined the extent to which African American individuals ascribe to mainstream, White culture, while others (e.g., Pumariega et al., 1994) have investigated the extent to which women identify with African American culture, specifically. The terms “ethnic identity” and “acculturation” (i.e., identification with White culture) seem to have been used interchangeably, which makes the findings difficult to compare. A strong identification with one’s ethnic group is a construct separate from acculturation (i.e., the rejection or embracement of White mainstream cultural values). Nonetheless, the mixed findings indicate a need for further research regarding ethnic identity and ED symptomatology with clearly defined constructs.

It would be informative to investigate the impact of ethnic identity on ED symptomatology and body image disturbance among African American women in order to identify unique protective factors among this group of women. Moreover, a gap exists in the research literature regarding whether a strong sense of ethnic identity moderates (i.e., buffers) the relation between stressful life events (e.g., racism) and ED symptomatology and body image, as no published study to date has investigated these relations.
Based on the research that suggests that the experience of stressful life events, in the absence of positive coping, leads to poor psychological adjustment (Phinney & Chavira, 1992) and eating disorder concerns (e.g., Strober, 1984), it is important to investigate what factors may buffer the relation between specific life stressors and ED symptomatology. With respect to African American women, who have undoubtedly experienced both racist and sexist events, it is important to examine what factors may buffer the effects of these stressful life events on ED symptomatology and body image concerns.

2.5 Double jeopardy?

In attempts to understand the unique sociocultural experiences of African American women, theorists and researchers have proposed several conceptualizations with regard to the impact of various forms of discrimination on the psychological health of African American women. Beal (1970) asserted that African American women are in a position of double jeopardy as a result of oppressions they face based on their racial and gender status. She proposed that both racism and sexism have direct effects on the psychological well-being of African American women. Furthermore, she asserted that both forms of oppression combine to create an additive impact on the lives of African American women (Moradi & Subich, 2003).

Extending conceptualizations of the additive components of racism and sexism, others (e.g., King, 1988) have proposed an interactionist perspective or a multiple jeopardy approach. These conceptualizations reflect not only the additive effects of racism and sexism, but also the multiplicative effects. The multiply jeopardy approach
has been described as “a statistical interaction effect – that is, a ‘unique space’ or ‘unique outcome’ that cannot be explained or predicted from knowledge of the main effects for status dimensions alone” (Landrine, Klonoff, Alcaraz, et al., 1995, p. 187; see also Moradi & Subich, 2003). According to this approach, it is assumed that one form of oppression (e.g., sexism) intensifies the impact of another form of oppression (e.g., racism; Moradi & Subich, 2003). In line with the “multiplicative effects” conceptualization, Greene (1994) proposed that the experience of racist events may overwhelm the coping resources of women who also experience sexist discrimination, which, in turn, leads to greater psychological distress.

Although conceptualizations have emerged underscoring the potential multiplicative and/or combinational effects of racism and sexism on the psychological distress of women of color, only one study to date has examined racist and sexist events concomitantly. Based on these conceptualizations, as well as empirical findings documenting positive correlations between both forms of oppression (i.e., sexism, racism), independently, and psychological distress (e.g., Landrine & Klonoff, 1996; Klonoff & Landrine, 1999; Landrine, Klonoff, Gibbs et al., 1995; Landrine & Klonoff, 1997), Moradi and Subich (2003) hypothesized that racist and sexist events have unique links to psychological distress. Furthermore, they proposed that racist and sexist events would interact to account for variance in psychological distress above and beyond that accounted for by their unique links among a sample of African American college and community women.

The findings from this study indicate that the experience of racist and sexist event may, in fact, be “fused” for African American women. Using path analysis, Moradi and
Subich (2003) found that, when examined separately, both racist and sexist events predicted greater psychological distress. These findings were consistent with previous research (e.g., Klonoff & Landrine, 1999). Interestingly, however, when racist and sexist events were examined together, only sexist events emerged as a unique predictor of psychological distress and there was no interaction effect (i.e., racist events X sexist events). As a result of these findings, the authors suggest yet another conceptualization of the roles of racism and sexism in the lives of African American women. Specifically, they assert that “overlap” appears to exist in African American women’s reports of racist and sexist events. In other words, perhaps the identities of being a woman and an African American are inextricably linked or “fused.”

These findings call into question previous conceptualizations that have proposed additive and/or multiplicative links of racism and sexism to African American women’s psychological distress (e.g., Beal, 1970; King, 1988). Moreover, the authors contend that the findings are consistent with emerging conceptualizations that challenge the dichotomization of racism and sexism in African American women’s lives (Collins, 1998). Along these lines, Collins (1991) proposed that multiple dimensions of oppression (e.g., racism, sexism) intersect to locate each group (e.g., African American women) within a social organizational system. Each group’s unique position within this system defines the group’s unique experiences of oppression. In other words, the whole of one’s oppression may be greater than the sum of its parts (Moradi & Subich, 2003). Thus overlap between responses to the measures of racist and sexist events may reflect actual overlap or fusion in the participants’ subjective experiences of racist and sexist discrimination (Moradi & Subich, 2003). For instance, if an African American woman is
threatened with harm or faces employment discrimination, she may attribute that experience to the fact that she is an *African American woman*, not that she is *African American* or a *woman* (Moradi & Subich, 2003).

Indeed, African American women firefighters in one study (Yoder & Aniakudo, 1997) refused to distinguish between experiences of racism and sexism, calling such a distinction artificial. Conversely, in other studies (e.g., Krieger, 1990), African American women identified both racism and sexism as independent sources of oppression. These seemingly contradictory findings may reflect within group differences. Accordingly, Moradi and Subich (2003) highlighted the importance of acknowledging both experiences (i.e., those that reflect the unique contributions of racism and sexism and those that reflect the combination of racism and sexism). The conceptualization of “intersectionality” captures separate dimensions of oppression as well as their potential fusion (Moradi & Subich, 2003).

According to their findings, Moradi and Subich (2003) caution researchers and practitioners from dichotomizing African American women’s experiences of racism and sexism, and underscore the importance of investigating both forms of oppression. The authors also encourage researchers and practitioners to attend to racial (e.g., Cross, 1971), feminist (Downing & Roush, 1985), and womanist (Ossana, Helms & Leonard, 1992) identity development to further understand the salience of racism and sexism for African American women’s psychological well-being. Hargrove (2000) echoes these scholars’ suggestions and emphasizes the importance of attending to both racial and gender identity as a means of respecting the collective identities of African American women.
Furthermore, the authors urge researchers to include multiple measures of psychological distress and to attend to potential protective factors that may serve to buffer the discrimination-psychological distress link (Moradi & Subich, 2003). The strong correlations found between racist/sexist discrimination experiences and psychological distress should direct researchers to consider resilience factors that may protect African American women from psychological distress in the face of racist and sexist discrimination (Moradi & Subich, 2003). In other words, if it is assumed that all African American women experience racist and sexist discrimination at some point in their lives and these forms of oppression often lead to various forms of psychological distress, including ED symptomatology and body image disturbance, what potential internal attributes moderate the relation between oppressive experiences and psychological distress? Or from a resilience perspective, do particular personal attributes such as a strong sense of ethnic and feminist identity allow African American women to maintain a positive body image and resist engaging in disordered eating patterns despite experiences with multiple forms of discrimination?

2.6 Summary and objectives

In sum, theorists and researchers have debunked perceptions that ED symptomatology and body image disturbance are concerns unique to European American women. In fact, researchers have documented the existence of body image disturbance and disordered eating behaviors among African American women and have suggested that such concerns may even be on the rise among this group of women. Based on empirical findings that document the deleterious effects of racism and sexism on the lives
of African American women, the present study seeks to investigate the effects of these forms of oppression on body image disturbance and disordered eating concerns.

In order to provide effective treatment and prevention services to African American women who struggle with ED and body image concerns, researchers and practitioners need to consider the unique sociocultural context of the African American woman’s experience. It should not be assumed that because one variable (e.g., pressure for thinness) is a strong risk factor for ED symptomatology and body image disturbance among European American women, the same factor applies to risk for African American women. Similarly, because a particular factor is considered protective against ED symptomatology and body image disturbance among European American women, the same does not necessarily hold true for African American women.

Rather than relying on such assumptions, it is important to empirically investigate risk and protective factors that may be specific to the life experiences of the group under study. Whether African American women suffer from these concerns at the same rate as European American women has been addressed and is not the focus of the present study. Instead, based on the empirical evidence that documents the existence of ED symptomatology and body image disturbance among African American, and the links between racist/sexist discrimination and ED symptomatology, the present study seeks to examine whether particular internal factors may protect or “shield” some African American women from these concerns.

Accordingly, the purpose of the current study was to investigate predictive and protective factors of ED symptomatology and body image disturbance among African
American women. First, in response to scholars’ recommendations to examine the fusion of racist and sexist discrimination, a new measure was created which reflects the blending of racist and sexist discrimination. Providing this instrument is found to be psychometrically strong, it will be used as a measure of “ethnogender discrimination,” reflecting the fusion of racism and sexism. Second, in a similar vein to the Sabik and Tylka (2006) study, the present study investigated whether particular positive feminist identity styles (i.e., Synthesis, Active Commitment) buffer the relation between ethnogender discrimination and ED symptomatology and one empirically supported predictor of ED symptomatology (i.e., body image dissatisfaction) among African American women.

Additionally, in response to the literature that has documented the deleterious effects of racist events on the psychological well-being of people of color (e.g., Moradi & Subich, 2003), as well the positive impact of strong ethnic identity on psychological adjustment (Phinney, 1992), ethnic identity was examined as it relates to resilience to ED symptomatology and body image disturbance. Specifically, ethnic identity was examined as a moderator of the relations between ethnogender discrimination and the two criterion variables (i.e., ED symptomatology, body image dissatisfaction). Finally, ethnic identity and feminist identity styles were examined together to determine whether the combination of these variables buffers the relation between ethnogender discrimination and the two criterion variables. Based on mounting empirical evidence which suggests that bulimic symptomatology may be a particularly relevant cluster of symptoms for African American women, a measure of bulimic symptomatology was used as the ED symptomatology criterion variable.
The hypotheses were three-fold: 1) ethnogender discrimination will predict ED symptomatology and body image dissatisfaction 2) active commitment and synthesis feminist identity styles and ethnic identity will moderate (i.e., buffer, weaken) the relations between ethnogender discrimination and the criterion variables (i.e., ED symptomatology, body image dissatisfaction) and 3) a strong sense of ethnic and feminist identity, together, will buffer the relation between ethnogender discrimination and the criterion variables.

The present study represents a contribution to the literature by examining culturally relevant variables in conjunction with disordered eating and body image dissatisfaction among African American women. More specifically, the present study examines factors that may operate as protective factors (i.e., feminist identity, ethnic identity) against disordered eating and one predictor (i.e., body image dissatisfaction) of EDs and ED symptomatology among a group of women that has, historically, been underrepresented in this area of research. The investigation of protective factors that lead to resilience against ED symptomatology, specifically among African American women, represents an important area of research that is, for the most part, “uncharted territory” in the research literature.

In addition, as recommended by Moradi and Subich (2003), the present study addresses whether the fusion of identities (i.e., ethnic identity and feminist identity) buffers the relation between multiple “isms” (i.e., racism, sexism) and the criterion variables. Such an investigation is especially relevant to counseling psychology, as this
discipline a) emphasizes the importance of addressing research from a resilience perspective and b) aspires to meet ethical and professional obligations to build and deliver culturally appropriate treatment and prevention programs reflective of empirically sound research endeavors.
CHAPTER 3

METHOD

3.1 Participants and procedures

Participants were 314 university-affiliated women ranging in age from 18-62 ($M = 22.28$, $SD = 6.84$). The majority of the participants identified as African American (86.1%) or biracial (11.3%). The remaining participants (2.6%) identified with one of the following groups: African American/Irish/Japanese, Black/Irish/French Creole/Native American, African American/Mexican/Filipino, African, Mixed American, and Ugandan American. Women classified themselves as freshmen (34.1%), sophomores (14.9%), juniors (15.9%), seniors (17.2%), post-baccalaureate (2.3%), and graduate students (11.6%). The remaining participants (4%) classified themselves as belonging to one of the following categories: continuing education, nontraditional student, PhD student, college graduate (PhD, Master’s degree), Juris Doctor Candidate, out of school, post-graduate, accelerated nursing student, medical student, professional student, first-year sophomore, some college, parent, and staff member.

The majority of the sample identified as single (65.4%) followed by those who were involved in long-term relationships (24.9%), married (6%), or divorced (2.3%). Five participants (1.3%) did not indicate current relationship status. Most of the participants described their socioeconomic status as middle class (49%) or working class
(36%) whereas fewer endorsed upper-middle (14.7%) or upper class (0.3%) labels. All but one participant were recruited from a large, predominantly White, Midwestern university.

Data was collected via an Internet survey. African American women enrolled in an introductory psychology course at a mid-western university represented 35% of the total sample. These participants received course credit for their participation. Participation was voluntary in the sense that students could choose from a variety of studies or write a paper in lieu of study participation. Based on incentive for participation (i.e., course credit) with this portion of the sample, and the concern that individuals who are not African American females might attempt to participate, participants were required to meet briefly with the investigator after completing the study in order to ensure that participants were, in fact, African American women. All participants in this portion of the sample appeared before the researcher following completion of the survey in order to keep the race/ethnicity (i.e. European American) of the researcher unknown until the surveys were completed. All participants were indeed African American women.

In an effort to obtain a sufficiently large and demographically diverse sample, an e-mail message was sent to 18 African American and multicultural college student organizations at predominantly White institutions and historically Black colleges across the country; the e-mail explained the purpose and nature of the study and included a request that the advertisement for the study be distributed to eligible students. Of these participants, all but one were associated with the same predominantly White, Midwest institution from which the rest of the sample was recruited. The participants recruited in this manner made up the rest of the sample (i.e., 65% of the total sample). Although the participants were recruited in different ways (i.e., advertisement through the university’s
organized research program, advertisement by an e-mail distributed by African American Student Services) the administration of the survey was identical for all participants.

Prior to completing the surveys, the participants viewed the e-mail solicitation for participation (see Appendix I), a brief description of the study (see Appendix J), and an informed consent form (see Appendix K) which explained security limitations of Internet data collection. Participants were informed that the security of the data would be guaranteed once the researcher received it. They were also informed that additional measures were employed (i.e., data encryption) to protect the security of their responses. Interested participants were directed to the World Wide Web by clicking on a link, provided in the e-mail message, which routed them directly to the site where they accessed and completed the questionnaires. The Internet method of data collection provided a convenient means for participants to access the survey (e.g., access via campus computers, home computers). The study was hosted online by SurveyMonkey, an Internet survey software company. SurveyMonkey provides the URL and server space for the data to be stored temporarily until administration is completed.

Following completion of the study, the participants were automatically redirected to a page with a detailed debriefing statement that elaborated on the purposes of the study, provided counseling referrals, and listed the contact information of the researcher and her advisor. No identifying information was collected, but participants not enrolled in the introductory psychology courses were given the option of including an e-mail address to be entered into a lottery to win fifty dollars. Participants recruited from the introductory psychology courses were not given the opportunity to enter the lottery drawing based on already existing course credit incentive. In order to ensure anonymity
of the participants who did participate in the lottery drawing, email addresses were collected and housed separately from the data sets.

Although Internet data collection has multiple strengths such as obtaining a large, demographically diverse sample, this method can also result in erroneous data (Schmidt, 1997). Therefore, several strategies to reduce the likelihood of obtaining erroneous data were incorporated. E-mail and IP addresses were carefully screened to ensure that the same individual did not submit the survey more than once. As recommended by Schmidt (1997) and Dillon and Worthington (2003), surveys were also screened by examining the date, time, and origin of submission. No duplicate surveys were found.

In order to control for intentional submission of inaccurate information, inattentiveness, and random responding, several items were included as validity checks. Two items asked participants to indicate their race/ethnicity (to screen out those who are not African American). Participants were also asked to indicate the race/ethnicity of their parents. As an additional validity check, two items were placed in the survey that instructed the participants to choose a specific response choice (e.g., “Please choose ‘Rarely’ for this question”). Participants were also asked to indicate their age and date of birth in order to ensure eligibility for consent. Twelve response sets were deleted based on failing one or more of the validity checks or based on incomplete data sets yielding a corrected N of 302 participants.

3.2. **Instruments**

Participants first completed a demographic questionnaire followed by the relevant instruments. Based on limitations to Internet data collection and in order to avoid bias in
responding, the measures employed for the purposes of the present study were
administered in following fixed order: The Schedule of Sexist Events, The Schedule of
Racist Events, The Ethnogender Discrimination Scale, The Feminist Identity Composite,
The Multi-Group Ethnic Identity Measure, The Body Esteem Scale, The Bulimia Test-
Revised, and Body Mass Index. Three additional measures were administered to the
participants, but were not included in the data analysis of the present study.

3.3 Demographic questionnaire

A brief questionnaire (see Appendix A) requesting personal information including
age, ethnic identification, relationship status, student status, and socioeconomic status
was also included within the measures.

3.4 Predictor variables

The proposed predictor variables of the current study are perceived sexist events,
perceived racist events, and ethnogender discrimination. The frequency of perceived
sexist events was measured by the The Schedule of Sexist Events (SSE). The Schedule
of Racist Events (SRE) was administered to measure the frequency of perceived racist
events. The Ethnogender Discrimination Scale (EDS) was created for use in the present
study and measured the perceived frequency of discrimination based on the fusion of race
and gender. Because the EDS was developed for the present study as a measure of the
fusion of racist and sexist events, the SSE and SRE were used to determine whether the
EDS yielded evidence of construct validity. Based on the preliminary analyses, only the
EDS was used in the main analyses exploring whether feminist identity and ethnic
identity moderated the discrimination-body dissatisfaction and the discrimination-bulimic
symptomatology relations.
3.4.1 **Perceived sexist events**

The Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995; see Appendix B) is a rationally developed instrument and contains 20 items that assess perceived frequency of more subtle forms of sexist discrimination both within one’s lifetime (SSE-Lifetime) as well as within the past year (SSE-Recent). Items are rated along a 6-point scale ranging from 1 (“the event never happened”) to 6 (“the event happened almost all the time”). A sample item is, “How many times have you been treated unfairly by your employer, boss, or supervisors because you are a woman?” Items are summed to obtain subscale scores (i.e., SSE-Lifetime, SSE-Recent); each subscale has a possible range of scores from 20 to 120. Higher scores indicate greater perceived sexist discrimination.

Internal consistency and split-half reliability estimates for the SSE scales have been reported to be high (.90s, .80s, respectively; Landrine & Klonoff, 1997) for a sample of 652 women (38% minority women, 6% Black). For a sample of 631 women (36% women of color, 6% Black), SSE-Recent and SSE-Lifetime scores have been found to correlate positively with measures of the frequency of daily hassles and major stressful life events (Klonoff & Landrine, 1995). Fischer et al. (2000) reported nonsignificant or negligible correlations between SSE scores and self-deceptive enhancement and impression management for a sample of 295 women (4% African American), supporting its discriminant validity.

Additional support for the instrument’s construct validity includes findings that SSE scores were positively related to feminist identity development (Fischer et al., 2000). Based on the conceptualization of recent sexist events as the most proximate predictor of psychological distress (Klonoff & Landrine, 1995) and the empirical documentation of
high correlations between the SSE subscale scores (Moradi & Subich, 2003), only SSE-Recent scores were examined in the current study. For the present study, the alpha of SSE-Recent was .92.

3.4.2 Perceived racist events

The Schedule of Racist Events (Landrine & Klonoff, 1996; see Appendix C) is an 18-item rationally developed instrument that assesses the frequency and appraisal of racist discrimination. Questions such as “How many times have you been accused or suspected of doing something wrong (such as stealing, cheating, not doing your share of work, or breaking the law)?” and “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 you are Black?” are illustrative of its content. The instrument uses a Likert-type scale ranging from 1 (“the event never happened to me”) to 6 (“the event happened almost all of the time”). Participants rate the items once for frequency of racist events within one’s lifetime (SRE-Lifetime), once for the frequency of racist events in the past year (SRE-Recent), and once for the perceived stressfulness of each event (SRE-Appraisal). Ratings across items are added to obtain scale scores that may range from 18-108 for SRE-Lifetime and SRE-Recent and from 17-102 for SRE-Appraisal (the last SRE item is not included in the Appraisal scale). Higher scores indicate greater frequency or stressfulness of perceived racist events.

Reliability, internal consistency and split-half estimates for the SRE subscales have been found to be in the .90s for a sample of 153 African American women and men (Landrine & Klonoff, 1996). In addition, SRE scores have been found to be related to Krieger’s (1990) measure of racist discrimination (54% women; Klonoff & Landrine,
and to be independent of age, income, and education for a sample of 520 African American respondents (53% women; Klonoff & Landrine, 1999). Only SRE-Recent scores were examined in the current study based on the following support in the research literature: recent racist events have been conceptualized as the most proximal and salient predictor of psychological distress (Landrine & Klonoff, 1996), empirical documentation indicates high correlations between the SRE subscales (Fischer & Shaw, 1999), and observations made by researchers have indicated a lack of clarity about the meaning of the appraisal scores (Fischer & Shaw, 1999). In the present study, coefficient alpha for SRE-Recent was .93.

3.4.3 Ethnogender discrimination

Based on theoretical speculations and empirical findings (e.g., Moradi & Subich, 2003), researchers (e.g., Moradi & Subich, 2003) have suggested that the experience of sexist and racist discrimination may be fused for African American women. More specifically, researchers have suggested that African American women may have difficulty determining whether they are being discriminated against based on race or gender. In order to measure the putative fusion in African American women’s experiences of discrimination, the Ethnogender Discrimination Scale (EDS; see Appendix D) was created by the author and was administered to the participants in the current study.

This measure was rationally developed directly from SSE (Klonoff & Landrine, 1995) and the SRE (Landrine & Klonoff, 1996) and consists of 42 items assessing the frequency of discrimination based on both race and gender. Items were taken directly from the SSE and SRE and were adapted to reflect a fusion of race/ethnicity and gender.
Questions such as “How many times have you been treated unfairly by strangers because you are an African American woman?” and “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 you are an African American woman?” are illustrative of its content.

The instrument uses a Likert-type scale ranging from 1 (“the event never happened to me”) to 6 (“the event happened almost all of the time”). Participants rate the items once for frequency of ethnogender discrimination within one’s lifetime (EDS-Lifetime) and once for the frequency of ethnogender discrimination in the past year (EDS-Recent). Ratings across items are added to obtain scale scores that may range from 21-126. Higher scores indicate greater frequency of perceived ethnogender discrimination. Although participants completed both Recent and Lifetime subscales, only Recent subscale scores were used in the current analyses. Coefficient alpha for the present study was .95.

3.5 Moderator variables

The proposed moderator variables of the current study are positive feminist identity style and ethnic identity. Positive feminist identity style was measured by two subscales (i.e., Active Commitment, Synthesis) of the Feminist Identity Composite. Ethnic identity was measured by The Multi-Group Ethnic Identity Measure.

3.5.1 Positive feminist identity

The Feminist Identity Composite (FIC; Fischer et al., 2000; see Appendix E) consists of 33 items and is the recommended instrument for assessing feminist identity (Moradi et al., 2002). Each style is represented as a subscale on the FIC, and a woman’s
level of each style is measured. The Passive Acceptance (PA) subscale contains 7 items (e.g., “I don’t see much point in questioning the general expectation that men should be masculine and women should be feminine”). The Revelation (R) subscale contains 8 items (e.g., “Gradually, I am beginning to see just how sexist society really is”). The Embeddedness-Emanation (EE) subscale contains 4 items (e.g., “I am very interested in women writers”). The Synthesis (SYN) subscale contains 5 items and reflects a positive self-concept and includes endorsement of positive attributes related to being a woman (e.g., “I feel like I have blended my female attributes with my unique personal qualities”). Finally, the Active Commitment (AC) subscale contains 9 items and reflects women’s commitment to social change and the belief that men are equal to, but not the same as women (e.g., “I care very deeply about men and women having equal opportunities in all respects”).

Each item is rated along a scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items are averaged to arrive at a total score; higher mean scores for each subscale indicate greater agreement with the corresponding feminist identity style. The SYN and AC styles can be conceptualized as more advanced feminist identity styles. Because the purpose of this study is to specifically examine advanced or positive feminist identity styles, only the SYN and AC subscale scores were used in the analyses.

Fischer et al. (2000) reported alpha levels of .68 and .71 for the SYN subscale and .77 and .81 for the AC subscale with two samples of college women. Sabik and Tylka (2006) found internal consistency estimates to be .75 and .72 for SYN and AC, respectively. Fischer et al. (2000) also garnered validity support for the FIC. They found that it adhered to a five-factor structure that resembled Downing and Roush’s (1985)
model, and that its subscales were negligibly correlated with social desirability but related, as expected, to ego identity status, perceptions of sexist events, and involvement in women’s organizations. No test-retest reliability information has been reported on this measure.

Fischer et al. (2000) also garnered validity support for the individual subscales. Specifically, both identity achievement and perception of sexist events were positively related to SYN and AC. In addition, they found AC to be negatively related to Passive Acceptance and unrelated to impression management and self-deceptive enhancement.

Regarding validity evidence for African American women, no published study to date of which the author is aware has investigated the psychometric properties of the FIC. However, White, Strube and Fisher (1998) provided validity evidence for the Feminist Identity Development Scale (FIDS, Bargad & Hyde, 1991) for African American community women. Specifically, these authors investigated rape myth acceptance versus rejection and found that advanced styles of feminist identity were positively related to rape myth rejection and that less advanced styles of feminist identity (e.g., Passive Acceptance) were related to rape myth acceptance among African American women. As the FIC was modeled after the FIDS and represents an improvement over the FIDS regarding psychometric strength, it seems plausible that the FIC may also be a valid instrument for use with African American college women.

The entire scale was administered to participants, but only the SYN and AC subscales were examined in the present study. Coefficient alphas for the SYN and AC subscales were .74 and .88, respectively.
3.5.2 Ethnic identity

The Ethnic Identity subscale of the Multi-Group Ethnic Identity Measure (MEIM-EI; Phinney, 1992; see Appendix F) contains 14 items (e.g., “I have a strong sense of belonging to my own ethnic group”) assessing ethnic identity achievement, affirmation and belonging, and ethnic behaviors. The measure was designed specifically for adolescents and young adults to measure feelings of belonging or pride, a secure sense of group membership, and positive attitudes for one’s ethnic group. Each item is rated on a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree). Item responses are averaged, and higher scores reflect higher levels of ethnic identity. An additional six items assess other group orientation. Also, three additional open-ended questions about ethnicity and parents’ ethnicity are not scored but are used as background information and were used as additional validity checks in the present study.

This instrument has yielded coefficient alpha scores ranging from .81 to .90 on samples of high school and college students, demonstrating acceptable internal consistency reliability (Phinney, 1992; Phinney, Cantu & Kurtz, 1997). In addition, one study with a sample of African American adult community women yielded an alpha of .91 (Beadnell, Stielstra, Baker, et al., 2003). Validity evidence has also been garnered for this instrument. For example, Phinney (1992) found a significant positive correlation between ethnic identity and self-esteem among African American high school and college students. For the present study coefficient alpha was .85.

3.6 Criterion variables

Body image dissatisfaction and ED symptomatology were the criterion variables examined in the current study. The Body Esteem Scale was administered, as this
measure appears to be a less culturally biased (as compared to more commonly used measures of body image dissatisfaction) for use with African American women. Specifically, this instrument does not assume that thinness represents the body image ideal for this group of women. With regard to ED symptomatology, bulimic symptomatology, specifically, was examined based on preliminary research findings indicating that bulimic symptomatology, which includes binge eating, is more common among African American women than are more restrictive forms of disordered eating. Accordingly, the Bulimia Test-Revised was employed to measure bulimic symptomatology.

3.6.1 Body image dissatisfaction

Body image dissatisfaction was measured using The Body Esteem Scale (BES, Franzoi & Shields, 1984; see Appendix G). The BES is a 35-item instrument with three subscales (i.e., Weight Concern, Sexual Attractiveness, Physical Condition). Participants are asked to respond to items on a 5-point Likert scale indicating their level of satisfaction with their bodies (i.e., 1 = strongly like to 5 = strongly dislike). Item scores are summed to arrive at a total score. The Weight Concern subscale consists of feelings concerning an individual’s weight, body build, appetite and various body parts including hips, legs and buttocks. The Sexual Attractiveness subscale includes items assessing feelings about sexual organs, appearance of stomach, chest/breasts, body scent and health. The Physical Condition subscale includes items assessing satisfaction with muscular strength, physical stamina, and agility.

Support has been garnered for the convergent and discriminant validity of the instrument as a multidimensional measure of body satisfaction among college women.
The BES has been found to be related to self-esteem among African American women college students yielding evidence for the instrument’s convergent validity with this population (Wade, 2003). The Weight subscale was able to discriminate between anorexic and non-anorexic participants yielding evidence for the instrument’s discriminant validity (Franzoi & Shields, 1984).

The BES has also demonstrated adequate reliability and consistency with subscale alpha values ranging from .78-.87 (Franzoi & Shields, 1984). Among undergraduate college students, internal consistency reliability for the overall scale has been as high as .92 (Tiggerman, 2001). Among young African American females and African undergraduate students, specifically, studies have demonstrated internal consistency reliability ranging from .80-.82 for the individual subscales and .92 for the overall scale (Wade, 2003; Frisby, 2004).

Based on scholars’ (e.g., Falconer & Neville, 2000; Miller et al., 2000) recommendations to include racially-relevant items when assessing body image among African American women, as well as empirical findings (e.g., Falconer & Neville, 2000; Miller et al., 2000; Wade, 2003) supporting the relevance of such items among African Americans, the following items were added to this measure: skin tone, skin color/shade, skin texture, hair thickness, hair length, hair texture, and hair color. The additional items were examined for internal consistency and were included in the total score. Accordingly, total scores can range from 42-210 with greater scores indicating higher body image dissatisfaction. For the present study, coefficient alpha was .94.
3.6.2 **Bulimic symptomatology**

Bulimic symptomatology was used in the current study to measure disordered eating based on findings that support the relevance of this particular cluster of symptoms for African American women (Cashel et al., 2003; Lester & Petrie, 1998; see also Striegel-Moore & Smolak, 1996). The Bulimia Test-Revised (BULIT-R; Thelen, Farmer, Wonderlich & Smith, 1991; see Appendix H) is a 28-item instrument which was designed to measure bulimia using definitions in the *Diagnostic and Statistical Manual, 3rd Edition, Revised* (DSM-III-R; American Psychiatric Association, 1987). More recently, the BULIT-R has also been validated using a sample of bulimic women and controls (Thelen, Mintz & Vander Wal, 1996) with the criteria from the Fourth Edition of the *Diagnostic and Statistical Manual* (DSM-IV; American Psychiatric Association, 1994).

The DSM-IV (American Psychiatric Association, 1994) set forth the following criteria for a diagnosis of bulimia nervosa: recurrent episodes of binge eating characterized by eating in a discrete period of time an amount that is larger than most people would eat during a similar time and under similar circumstances, with a sense of lack of control over eating; recurrent inappropriate compensatory/weight control behaviors (e.g., self-induced vomiting, misuse of laxatives, diuretics, enemas, fasting, excessive exercise); binge eating and compensatory behaviors both occur at least twice a week for a duration of three months, on average; self-evaluation is unduly influenced by weight or body shape; the disturbance does not occur exclusively during episodes of anorexia nervosa (DSM-IV; American Psychiatric Association, 1994, pp. 549-550). The measure was developed with rigorous psychometric procedures using six separate
samples of bulimic and control participants (all females) and was intended to be used to screen individuals for bulimia and to measure change during treatment (Thelen & Smith, 1994).

Individuals are instructed to rate each item on a continuous scale ranging from 1, indicating lack of endorsement of bulimic symptomatology, to 5, indicating strong endorsement of bulimic symptomatology. Although item scores are typically summed to arrive at a total score, in the current study items scores were averaged to provide a clearer picture of the range of bulimic symptomatology. Scores, then, can range from 1 to 5, with higher scores indicating more severe bulimic symptomatology. Items such as “I am afraid to eat anything for fear that I won’t be able to stop” and “After I binge eat I turn to one of several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics)” are illustrative of its content. Eight filler items are not included in the total score.

In a sample of 23 women with bulimia and 157 normal college females, the internal consistency reliability for the BULIT-R was .97 (see Thelen & Smith, 1994). Test-retest over a two-month period was .95, supporting the stability of the instrument (see Thelen & Smith, 1994). With a summed cut-off score of 104 (or an average score of 3.7) or greater, the BULIT-R has demonstrated validity with both clinically identified bulimic samples and nonclinical college female samples (see Thelen, Mintz & Vander Wal, 1996). Although a cut off score of 104 has been suggested, Thelen and Smith (1994) recommend a cut off score of 85 (or an average score of 3.0) in order to reduce the possibility of false negatives. The BULIT-R has been found to correlate highly with two other measures of bulimia, lending support for its construct validity (Thelen & Farmer,
1991). With regard to utility among African American women, the original BULIT (Smith & Thelen, 1984), which correlates nearly perfectly with the BULIT-R ($r = .99$, $p < .0001$; see Atlas, Smith, Hohlstein, McCarthy & Kroll, 2002), has been found to be invariant across race with a sample of Caucasian and African American college women (Atlas, et al., 2002). For the present study, coefficient alpha was .92.

### 3.7 Body mass index

Based on the theoretical speculations and empirical findings regarding the importance of body mass index (BMI) with respect to African American women’s level of body image disturbance and ED symptomatology, height and weight data was also collected via self-report in order to calculate participants’ BMI. Previous studies (e.g., Brooks-Gunn, Burrow, & Warren, 1988) have demonstrated that self-reported heights and weights are adequate for research purposes. Additionally, BMI has been used in prior research with ethnic minority college women (Lester & Petrie, 1998). The BMI is used to calculate body mass and takes into account an individual’s weight and height to gauge degree of adiposity. It is defined as weight (kg)/height (m²). According to the Centers for Disease Control and Prevention (CDC), BMI can be conceptualized into the following categories: underweight, below 18.5; normal weight, 18.5 to 24.9; overweight, 25 to 29.9; obese, 30 or greater. Body mass index was controlled for by partiaing out its variance in the regression analyses.

Refer to Figure 3.1 for an illustration of the variables examined and the measures utilized in the current study.

### 3.8 Research design/Data analysis

Hierarchical moderated regression (HMR) was employed to determine whether
the proposed moderating variables (i.e., positive feminist identity-AC, positive feminist identity – SYN, ethnic identity – EI) weaken the relations between the proposed predictor (i.e., EDS) and the criterion variables (i.e., bulimic symptomatology, body image dissatisfaction). Barron and Kenny’s (1986) procedure for determining whether variables moderate the relation between two variables was followed. Accordingly, BMI was entered at Step 1 of the analysis. The predictor variable (i.e., EDS) and the potential moderator variable (e.g., AC) were entered at Step 2 of the analysis. Finally, at Step 3, the predictor was the interaction term reflecting the product of the predictor and moderator (e.g., EDS X AC). A statistically significant increment in $R^2$ at Step 3, respectively, with effect size of .02 supports a moderator effect. Refer to Figure 3.2 for an illustration.

Following recommendations from researchers to examine how identities blend to predict criteria (Moradi & Subich, 2003), a collective analysis was also executed in which BMI was entered at Step 1, and the predictor variable and proposed moderators (i.e., EDS, AC, SYN, EI) were entered in at Step 2. Step 3 represented the interaction of these variables (i.e., EDS X AC, EDS X SYN, EDS X EI). A statistically significant increment in $R^2$ at Step 3, respectively, with effect size of .02 supports a moderator effect. It may be that both ethnic identity and feminist identity predict body image dissatisfaction and bulimic symptomatology when examined in separate analyses, but only one of these variables predicts the criteria when they are examined concomitantly. Such a finding would indicate a fusion of feminist and ethnic identities (Moradi & Subich, 2003). Refer to Figure 3.3 for an illustration.
Figure 3.1
Nomological Network Illustrating Predictor, Proposed Moderator and Criterion Variables, and Measures Used.
Figure 3.2
Illustration of Hypotheses that, Controlling for BMI, Three Proposed Moderator Variables (i.e., Active Commitment, Synthesis, Ethnic Identity) Will Buffer the Relations Between Ethnogender Discrimination and Bulimic Symptomatology and Ethnogender Discrimination and Body Image Dissatisfaction.
Figure 3.3
Illustration of Hypotheses that, Controlling for BMI, Three Proposed Moderator Variables (i.e., Active Commitment, Synthesis, Ethnic Identity) Combined Will Buffer the Relations Between Ethnogender Discrimination and Bulimic Symptomatology and Ethnogender Discrimination and Body Image Dissatisfaction
CHAPTER 4

RESULTS

4.1 Preliminary analysis of the Ethnogender Discrimination Scale

In order to determine whether the Ethnogender Discrimination Scale (EDS) adequately reflects the fusion of the perception of racist and sexist events, the EDS was first examined for internal consistency reliability and content validity. To determine the internal consistency of the EDS, Cronbach’s alpha and item-total correlations were examined. Alpha was .95 and corrected item-total correlations ranged from .52 to .78 (mean = .67). These values support the internal consistency content validity of the EDS.

Next, to determine if the EDS adequately reflected a fusion of racist and sexist discrimination, correlations between the SRE, SSE and EDS scores were examined. As expected, EDS scores were strongly associated with perceptions of racist events ($r = .86$, $p < .01$) and perceptions of sexist events ($r = .79$, $p = .01$). These findings provide initial support for the construct validity of the EDS. Also, as expected the SRE and SSE scores were highly correlated ($r = .74$, $p = .01$). Taken collectively, these findings provide evidence for the fusion of perceptions of racist and sexist events as Moradi and Subich (2003) proposed.

Given that statistically significant interactions are notoriously difficult to detect (McClelland & Judd, 1993; Sabik & Tylka, 2006), it is important to limit the number of
regressions examined in a particular data set. Based on the internal consistency of the EDS, the strong correlations between the SRE, SSE, and the EDS, and the previous empirical evidence indicating that multiple forms of discrimination appear to be fused for African American women (Moradi & Subich, 2003) only the EDS scores were examined in the primary analyses.

4.2 Descriptive statistics

Means and standard deviations for the examined variables are presented in Table 4.1. The mean score ($M = 41.82; SD = 16.68$) on the EDS indicates endorsement of ethnogender discrimination at least “once in awhile” in the past year and was comparable to means of the SRE-Recent ($M = 40.99, SD = 17.33; M = 38.00, no SD reported$) and SSE-Recent ($M = 39.04, SD = 14.01; M = 37.32, SD = 16.16$) as reported by Moradi and Subich (2003) in samples of African American university and community women.

The means obtained on the Synthesis ($M = 4.52; SD = .47$) and Active Commitment subscales ($M = 3.83; SD = .67$) of the FIC were comparable to those found in prior studies with predominately Caucasian women (e.g., Fischer et al., 2000; Sabik & Tylka, 2006) and can be conceptualized as moderate to high endorsement of positive feminist identity styles. Similarly, the mean score on the MEIM-EI (i.e., $M = 3.34; SD = .42$) was comparable to means scores found in previous samples of African American community women and adolescents (see Beadnell et al., 2003) and represents moderate to strong endorsement of ethnic identity .

The average score on the BULIT-R ($M = 1.63, SD = .54$) was comparable to mean scores in previous samples of African American and Caucasian college women (see Lester & Petrie, 1998) and indicates low levels, although not absence of bulimic
symptomatology. In order to compare BES scores to those in another sample, the BES scores in the current study were reverse scored and the additional race relevant items were removed. Accordingly, the new mean score ($M = 136.39; SD = 23.16$) on the BES was nearly identical to the mean score ($M = 136.82$, no $SD$ reported) found in another sample of African American college students (Miller et al., 2000) and indicates moderate to high levels of body esteem.

The average score ($M = 25.61; SD = 5.68$) on the BMI was similar to the mean score in another sample of African American college women ($M = 25.1, SD = 5.78$; Falconer & Neville, 2000) and is conceptualized by the Center For Disease Control and Prevention (CDC) to be on the high end of normal weight to the low end of overweight. According to the BMI categories set forth by the CDC, 3% of the current sample was classified as underweight, 54.9% of the sample was classified as normal weight, 24.2% was classified as overweight, and 17.9% of the sample was classified as obese.

Intercorrelations for the examined variables are also presented in Table 4.1. Values of $r$ of .10 and .13 are statistically significant at the .01 and .05 alphas levels, respectively. However, only $r$ values at or above .20 were considered practically significant (Walsh & Betz, 2001).

As expected, BMI, ethnogender discrimination, and body image dissatisfaction were significantly correlated ($p < .01$) with bulimic symptomatology. Specifically, each of these variables was positively related to bulimic symptomatology indicating that higher BMI, perceived ethnogender discrimination, and body image dissatisfaction are related to higher levels of bulimic symptomatology. Interestingly, ethnogender discrimination was positively related to one of the proposed moderators (i.e., active
commitment) indicating that higher levels of perceived ethnogender discrimination are related to higher levels of active commitment. Surprisingly, none of the proposed moderator variables (i.e., active commitment, synthesis, ethnic identity) were significantly correlated with bulimic symptomatology. It was expected that the three proposed moderators would be inversely related to bulimic symptomatology; however no significant correlations were found between the proposed moderator variables and bulimic symptomatology.

Also as hypothesized, BMI and all three proposed moderators (i.e., active commitment, synthesis, ethnic identity) were significantly correlated ($p < .01$) with body image dissatisfaction in the directions expected. Specifically, BMI was positively related to body image dissatisfaction; and synthesis, active commitment, and ethnic identity were negatively correlated with body image dissatisfaction. These findings indicate that higher levels of BMI are related to higher levels of body image dissatisfaction whereas higher levels of synthesis, active commitment, and ethnic identity are related to lower levels of body image dissatisfaction. Unexpectedly, the proposed predictor (i.e., ethnogender discrimination) was not significantly correlated with body image dissatisfaction.

4.3 **Hierarchical Moderated Regression (HMR)**

As specified by Frazier, Tix, and Barron (2004), hierarchical moderated regression (HMR; Evans, 1991) analyses were employed to test whether each proposed moderator variable interacted with ethnogender discrimination to predict bulimic symptomatology and body image dissatisfaction. This analysis is considered (e.g., Aiken & West, 1991; Frazier, Tix & Barron, 2004) the preferred statistical strategy for identifying the presence and nature of moderating effects. Moderators may or may not be
related to the predictor or the criterion, and the predictor may or may not be related to the criterion (Frazier et al., 2004). As recommended (e.g., Cronbach, 1987), scale scores for the predictor and the moderator variables were centered to reduce multicollinearity between the main effect and interaction terms.

To control for variance accounted for by BMI, this variable was entered at Step 1 of each analysis. Following the HMR procedure discussed by Aiken and West (1991), the predictor (i.e., ethnogender discrimination) and proposed moderator variable (e.g., active commitment) were entered at Step 2 of each analysis. Next, at Step 3, the interaction term (e.g., ethnogender discrimination X active commitment) was entered. Because statistically significant interactions are difficult to detect in nonexperimental designs, the use of liberal alphas (e.g., .10 or .25) has been recommended (McClelland & Judd, 1993). Nevertheless, because of the number of hierarchical moderated regressions performed in the present study (i.e., 8), and to control for experiment-wise error, the Bonferroni correction was employed yielding a corrected alpha of .013 (.10/8).

Because statistical significance is only one measure of a variable’s contribution to the criterion, and regression analyses are sensitive to sample size (McClelland & Judd, 1993), effect size also was considered. Specifically, a statistically significant increment in $R^2$ (i.e., $\Delta R^2$) and beta weight at Step 3 of each analysis is evidence for a moderator effect. Following the recommendations of Cohen (1992), it was determined that $\Delta R^2$ values of .02 and above would signify unique contributions to the overall variance.

Contrary to hypotheses, none of the proposed moderators buffered the relation between the predictor variable (i.e., ethnogender discrimination) and the two criterion variables (i.e., bulimic symptomatology, body image dissatisfaction). It was expected
that ethnogender discrimination would not predict bulimic symptomatology and body image dissatisfaction for women high on the proposed moderators (i.e., active commitment, synthesis, ethnic identity), but would predict bulimic symptomatology and body image dissatisfaction for women low on the proposed moderators, thus supporting the hypotheses that positive feminist and ethnic identities buffer the discrimination-bulimic symptomatology and discrimination-body image dissatisfaction relations. However, the interactions were not significant, thus refuting the moderator hypotheses.

Results from each regression analysis are presented in Tables 4.2, 4.3, 4.4, and 4.5. The following four sections discuss the results of the regression analyses for each proposed moderator (i.e., active commitment, synthesis, ethnic identity) independently and the collective analyses of all three moderators and each criterion variable (bulimic symptomatology, body image dissatisfaction).

4.3.1 Positive feminist identity - Active commitment

Unexpectedly, active commitment (AC) was not found to interact with ethnogender discrimination in predicting bulimic symptomatology ($\beta = .33$), $t(301) = .87$, $ns$ ($\Delta R^2 = .00$). Thus, the hypothesis that AC would moderate the relation between ethnogender discrimination and bulimic symptomatology was not supported. It is noteworthy that ethnogender discrimination, as an independent predictor, was found to positively predict bulimic symptomatology ($\beta = .17$), $t(301) = 3.19$, $p < .013$), whereas AC did not predict bulimic symptomatology ($\beta = .05$), $t(301) = .10$, $ns$). The results of these analyses are presented in Table 4.2.

Also contrary to hypotheses, AC was not found to interact with ethnogender discrimination in predicting body image dissatisfaction ($\beta = .13$), $t(301) = .32$, $ns$ ($\Delta R^2 = $
Thus the hypothesis that AC would moderate the relation between ethnogender discrimination and body image dissatisfaction was not supported. It is important to note that AC, as an independent predictor was found to predict lower levels of body image dissatisfaction ($\beta = -.18$, $t(301) = -3.21, p < .013$), while ethnogender discrimination did not predict body image dissatisfaction ($\beta = -.01$, $t(301) = -.01, ns$). The results of these analyses are presented in Table 4.3.

4.3.2 Positive feminist identity - Synthesis

Contrary to hypotheses, synthesis (SYN) was not found to interact with ethnogender discrimination in predicting bulimic symptomatology ($\beta = .33$, $t(301) = .56, ns$ ($\Delta R^2 = .00$). Thus, the hypothesis that SYN would moderate the relation between ethnogender discrimination and bulimic symptomatology was not supported. Similar to the findings with AC, ethnogender discrimination, as an independent predictor, was found to positively predict bulimic symptomatology ($\beta = .19$, $t(301) = -3.73, p < .013$), whereas SYN did not predict bulimic symptomatology ($\beta = -.11$, $t(301) = -2.14, ns$). The results of these analyses are presented in Table 4.2.

Also contrary to hypotheses, SYN was not found to interact with ethnogender discrimination in predicting body image dissatisfaction ($\beta = .20$, $t(301) = .34, ns$ ($\Delta R^2 = .00$). Thus the hypothesis that SYN would moderate the relation between ethnogender discrimination and body image dissatisfaction was not supported. Once again, as was the case with AC, SYN predicted lower levels of body image dissatisfaction ($\beta = -.27$, $t(301) = -5.11, p < .013$) while ethnogender discrimination did not predict body image dissatisfaction ($\beta = -.02$, $t(301) = -.39, ns$).
4.3.3 Ethnic identity

Surprisingly, ethnic identity (EI) was not found to interact with ethnegender discrimination in predicting bulimic symptomatology ($\beta = .07$, $t(301) = .18$, $ns$ ($\Delta R^2 = .00$). Thus, the hypothesis that EI would moderate the relation between ethnegender discrimination and bulimic symptomatology was not supported. As was the case with the other proposed moderators, ethnegender discrimination, as an independent predictor, was found to positively predict bulimic symptomatology ($\beta = .20$, $t(301) = 3.84$, $p < .013$), whereas EI did not predict bulimic symptomatology ($\beta = -.12$, $t(301) = -2.37$, $ns$). The results of these analyses are presented in Table 4.2. These findings challenge previous assumptions that EI serves as a buffer against specific forms of psychological distress (i.e., bulimic symptomatology) in the face of discrimination for African American women.

Also contrary to hypotheses, EI was not found to interact with ethnegender discrimination in predicting body image dissatisfaction ($\beta = .57$, $t(301) = 1.43$, $ns$ ($\Delta R^2 = .01$). Thus the hypothesis that EI would moderate the relation between ethnegender discrimination and body image dissatisfaction was not supported. Once again, as was the case with the additional proposed moderator variables, EI predicted lower levels of body image dissatisfaction ($\beta = -.39$, $t(301) = -7.81$, $p < .013$), while ethnegender discrimination did not predict body image dissatisfaction ($\beta = .01$, $t(301) = .19$, $ns$). The results of these analyses are presented in Table 4.3.

4.3.4 Collective analyses

When examined concomitantly, none of the proposed moderators (i.e., AC, SYN, EI) interacted with ethnegender discrimination in predicting bulimic symptomatology.
(see Table 4.4) or body image dissatisfaction (see Table 4.5). When bulimic symptomatology was examined as the criterion variable, only ethnogender discrimination emerged as an independent predictor, as was the case in the independent analyses. Interestingly, however, when body image dissatisfaction was examined as the criterion variable, only ethnic identity emerged as an independent predictor. This finding contrasted with the findings in the independent analyses in which all three proposed moderators independently predicted body image dissatisfaction. When examined concomitantly, only ethnic identity emerged as an independent predictor of body image dissatisfaction, supporting a fusion of ethnic and feminist identities.
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\[M \]

\[
\begin{array}{cccccccc}
\text{M} & 41.82 & 3.83 & 4.52 & 3.34 & 1.63 & 85.60 & 25.61 \\
\text{SD} & 16.68 & .67 & .47 & .42 & .54 & 25.96 & 5.68 \\
\end{array}
\]

Table 4.1


*Note.* For \(N = 302\), values of \(r\) of .10 and .13 are statistically significant at the .05 and .01 alpha levels, respectively. However, values of \(r\) below .20 are not considered practically significant (Walsh & Betz, 2001). The means and standard deviations were derived from the non-centered variables and averaged or summed total scores.
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| Step 1    |     |        |         |                  |            |                   |       |
| BMI       | .04 | .01    | .43     | .19              | .18        | .19               | 8.25* |
| Step 2    |     |        |         |                  |            |                   |       |
| EDS       | .01 | .00    | .19     | .23              | .22        | .04               | 3.73* |
| SYN       | -.13| .06    | -.11    | -.11             | -2.14      |                   |       |
| Step 3    |     |        |         |                  |            |                   |       |
| EDS X SYN | .00 | .00    | .33     | .23              | .22        | .00               | .56   |

| Step 1    |     |        |         |                  |            |                   |       |
| BMI       | .04 | .01    | .43     | .19              | .18        | .19               | 8.25* |
| Step 2    |     |        |         |                  |            |                   |       |
| EDS       | .01 | .00    | .20     | .23              | .22        | .05               | 3.84* |
| EI        | -.16| .07    | -.12    | -.12             | -2.37      |                   |       |
| Step 3    |     |        |         |                  |            |                   |       |
| EDS X EI  | .00 | .00    | .07     | .23              | .22        | .00               | .18   |

Table 4.2
Hierarchical Multiple Regression Analyses Predicting Bulimic Symptomatology From Perceived Ethnogender Discrimination (EDS), Active Commitment to a Feminist Identity (AC), Synthesis of Feminist Identity (SYN), Ethnic Identity (EI) and Interactions (N = 302).

Adj. = adjusted
* $df = 301$
* $p < .013$
Table 4.3
Hierarchical Multiple Regression Analyses Predicting Body Image Dissatisfaction From Perceived Ethnogender Discrimination (EDS), Active Commitment to a Feminist Identity (AC), Synthesis of Feminist Identity (SYN), Ethnic Identity (EI) and Interactions (N = 302).

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Adj. = adjusted
* $df = 301$
* $p < .013$
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Table 4.4
Hierarchical Multiple Regression Collective Analyses Predicting Bulimic Symptomatology From Perceived Ethnogender Discrimination (EDS), Active Commitment to a Feminist Identity (AC), Synthesis of Feminist Identity (SYN), Ethnic Identity (EI) and Interactions (N = 302).

Adj. = adjusted
* df = 301
* p < .013
Table 4.5
Hierarchical Multiple Regression Collective Analyses Predicting Body Image
Dissatisfaction From Perceived Ethnogender Discrimination (EDS), Active Commitment
to a Feminist Identity (AC), Synthesis of Feminist Identity (SYN), Ethnic Identity (EI) and
Interactions (N = 302).

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Adj. = adjusted
* $df = 301$
* * $p < .013$
5.1 **Review of the objectives**

Despite the vast body of extant research literature regarding disordered eating and body image dissatisfaction among European American women, knowledge about predictors and protective factors of eating disorder (ED) symptomatology and correlates of disordered eating among African American women is still limited. Although the extant eating disorders and body image literatures are useful for creating hypotheses for African American women, scholars have emphasized the importance of considering the unique life context of African American women when investigating predictive and protective factors of ED symptomatology and body image disturbance in order to yield the most culturally relevant models of disordered eating and associated symptomatology.

The major aim of the present study was to attend to the gap in the research literature regarding which particular factors may predict and/or protect African American women from ED symptomatology and body image dissatisfaction. Although scholars have begun to examine correlates of disordered eating and body image dissatisfaction among African American women, studies have produced equivocal results. In order to attend to the dearth of information in the literature and to clarify the mixed findings regarding disordered eating and body image dissatisfaction, the following variables were
examined among a sample \( N = 302 \) of African American, university-affiliated women: ethnogender discrimination, adiposity (i.e., BMI), positive feminist identity-active commitment (AC), positive feminist identity-synthesis (SYN), ethnic identity (EI), body image dissatisfaction, and bulimic symptomatology. As racism and sexism are two forms of discrimination that are relevant in the lives of African American women and are associated with increased psychological distress (e.g., Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Moradi & Subich, 2003) a measure was created to examine the fusion of these variables (i.e., ethnogender discrimination). Scholars (e.g., Beal, 1970) have indicated that African American women are in a position of “double jeopardy” for psychological distress as both their race and gender are simultaneous targets for attack on their person (e.g., Landrine & Klonoff, 1996). In response to theoretical speculations and previous empirical findings (e.g., King, 2003; Moradi & Subich, 2003) which indicate that African American women are in a position of “double jeopardy” with regard to discrimination and psychological distress, and that discrimination may lead to disordered eating and body image dissatisfaction, specifically, (e.g., Thompson, 1996), ethnogender discrimination (i.e., the fusion of racist and sexist discrimination) was examined as a predictor of bulimic symptomatology and body image dissatisfaction.

In addition, in line with recent theoretical speculations and preliminary empirical findings (e.g., Pumariega et al., 1994; Sabik & Tylka, 2006) indicating that embracing multiple identities may serve a protective function against disordered eating and body image disturbance, ethnic identity and two positive feminist identity styles (i.e., AC, SYN) were examined as potential moderators (i.e., buffers) between discrimination and the two criterion variables (i.e., bulimic symptomatology, body image dissatisfaction).
Thus, the present study addressed three important questions raised in the literature: Generally, which variables predict and/or protect African American women from disordered eating and correlates of disordered eating? Specifically, does ethnogender discrimination predict disordered eating and body image dissatisfaction among African American women? And, if so, does a strong sense of ethnic identity and/or feminist identity protect African American women against disordered eating and body image dissatisfaction even in the face of discrimination? This study represents the first to examine the fusion of sexist and racist discrimination (i.e., ethnogender discrimination) and its impact on disordered eating and body image dissatisfaction. In addition, this study is the first of which the author is aware to explore both gender and ethnic identities as protective factors against disordered eating and body image dissatisfaction within the context of discrimination among African American women.

The rationale for examining whether variables weaken the discrimination-bulimic symptomatology and discrimination-body image dissatisfaction relations was that this type of investigation could increase our knowledge regarding which factors protect some African American women from engaging in disordered eating and experiencing body image disturbance. In other words, what strengths do some African American women possess which make them resilient to disordered eating and body image disturbance despite their experiences with discrimination and even a cultural milieu (i.e., Western culture) that, arguably, promotes such behavior? Identifying such moderating variables is essential, as this knowledge would help professionals understand which strengths are salient for their African American female clients. With this knowledge, professionals will be equipped to facilitate the enhancement of these strengths to help their African
American female clients manage and cope with discrimination and, in turn, reduce disordered eating patterns and body image disturbance which may result from the distress associated with multiple forms of discrimination. The major intent of this study was to begin the construction of a culturally relevant model of resilience to EDs and ED symptomatology among African American women.

5.2 Summary of the results

In order to begin addressing the questions raised by researchers, three theoretically relevant (Sabik & Tylka, 2006; Striegel-Moore & Smolak, 1996) variables, positive feminist identity-AC, positive feminist identity-SYN, and ethnic identity, were examined to determine whether they weakened the relations between 1) ethnogender discrimination and bulimic symptomatology and 2) ethnogender discrimination and body image dissatisfaction. Based on research literature that underscores the importance of adiposity with regard to disordered eating and body image disturbance, body mass index (BMI) was controlled for in the regression analyses.

As hypothesized, BMI, ethnogender discrimination, and body image dissatisfaction were significantly correlated with bulimic symptomatology. Specifically, each of these variables was positively related to bulimic symptomatology indicating that higher BMI, perceived ethnogender discrimination, and body image dissatisfaction are associated with higher levels of bulimic symptomatology. The findings of the current study support previous findings that BMI predicts body image dissatisfaction (e.g., French et al., 1997) and bulimic symptomatology (e.g., Lester & Petrie, 1998). Additionally, the findings of the current study support previous findings indicating that body image dissatisfaction (e.g., Lester & Petrie, 1998) and discrimination (e.g.,
Talleyrand, 2002) are correlated with bulimic symptomatology among African American women. The finding that ethnogender discrimination is positively related to disordered eating represents an important contribution to the literature as only one study to date has investigated the relation between perceptions of racial stressors and disordered eating and no published study to date has investigated the relations between 1) discrimination and body image dissatisfaction or 2) the fusion of racism and sexism and disordered eating among African American women.

Surprisingly, none of the proposed moderator variables (i.e., AC, SYN, EI) were significantly correlated with bulimic symptomatology. In other words, none of the proposed moderators were associated with low levels of bulimic symptomatology as expected. These findings were surprising based on empirical findings (e.g., Sabik & Tylka, 2006) and theoretical speculations that a strong feminist identity and a strong ethnic identity would predict lower levels of disordered eating. The findings in the present study did not support this assertion.

As hypothesized, BMI and all three proposed moderators (i.e., AC, SYN, EI) were significantly correlated with body image dissatisfaction in the directions expected. Specifically, BMI was positively related to body image dissatisfaction, and AC, SYN, and EI were negatively correlated with body image dissatisfaction. These findings indicate that higher levels of BMI are related to higher levels of body image dissatisfaction whereas higher levels of AC, SYN, and EI are related to lower levels of body image dissatisfaction. These findings support previous assumptions that higher levels of feminist and ethnic identities would predict higher levels of body esteem (i.e., lower levels of body image dissatisfaction) among African American women. Similar to
the findings with regard to bulimic symptomatology, BMI predicted higher levels of body image dissatisfaction (i.e., lower levels of body esteem). Thus, the current findings support similar relations (i.e., positive) between BMI, body image dissatisfaction, and bulimic symptomatology to those which have been supported among European American women. Unexpectedly, the proposed predictor (i.e., ethnogender discrimination) was not significantly correlated with body image dissatisfaction. It was expected that higher levels of ethnogender discrimination would be associated with higher levels of body image dissatisfaction; however the findings of the present study did not support this hypothesis.

Of the eight regression analyses performed, none of the interactions were found to be significant. Surprisingly, neither form of positive feminist identity (i.e., AC, SYN) was found to interact with ethnogender discrimination in predicting bulimic symptomatology. Thus, the hypotheses that AC and SYN would buffer the relation between ethnogender discrimination and bulimic symptomatology were not supported. In other words, the effect of discrimination on bulimic symptomatology was not impacted by positive feminist identity as defined by the measures used in the current study.

Although these hypotheses were not supported, the null findings provide an important contribution to the extant literature. Specifically, these findings support the assertion that predictive and/or protective factors for African American women may differ from those of European American women. For example, Sabik and Tylka (2006) found that both AC and SYN buffered the relation between perceived sexist discrimination and ED symptomatology. The majority of their participants, however, were European American college women. The contrast between these findings
underscores the need to empirically examine factors that are relevant for diverse groups of women and the importance of being cautious when applying findings across groups.

It is noteworthy that ethnogender discrimination, as an independent predictor, was found to positively predict bulimic symptomatology whereas AC and SYN did not predict bulimic symptomatology. These findings indicate that additional variables may be operating to buffer the ethnogender discrimination-bulimic symptomatology link. More specifically, if ethnogender discrimination predicts bulimic symptomatology and most African American women experience discrimination (over 95% of the current sample experienced a discriminatory event at least once in awhile in the past year), why does only a subset of the African American female population engage in disordered eating?

Perhaps other unexplored variables strengthen or weaken the discrimination-disordered eating link such that those women who exhibit high levels of a particular trait are able to cope with discrimination in more adaptive ways. For example, ample empirical evidence exists to support the buffering effect self-esteem can have on psychological distress. Although AC and SYN did not buffer the discrimination-disordered eating link, perhaps self-esteem or some other variable (or combination of variables) buffers this relation. It would be worthwhile to empirically examine additional theoretically relevant variables to determine whether certain traits buffer the discrimination-disordered eating relation.

Also contrary to hypotheses, AC and SYN were not found to interact with ethnogender discrimination in predicting body image dissatisfaction. Thus the hypothesis that positive feminist identity would moderate the relation between ethnogender
discrimination and body image dissatisfaction were not supported. It is important to note that both AC and SYN, as independent predictors, were found to predict lower levels of body image dissatisfaction, while ethnogender discrimination did not predict body image dissatisfaction. Accordingly, it would behoove researchers to explore whether positive feminist identity (i.e., AC, SYN) buffers the relation between other documented predictors (e.g., sociocultural pressure for thinness) and body image dissatisfaction.

Perhaps most surprisingly, ethnic identity (EI) was not found to interact with ethnogender discrimination in predicting bulimic symptomatology. Thus, the hypothesis that EI would moderate the relation between ethnogender discrimination and bulimic symptomatology was not supported. As was the case with the other proposed moderators, ethnogender discrimination, as an independent predictor, was found to positively predict bulimic symptomatology, whereas EI did not predict bulimic symptomatology. These findings challenge previous assumptions that EI serves as a buffer against specific forms of psychological distress (e.g., bulimic symptomatology) in the face of discrimination for African American women.

It is important to note, however, that the conservative alpha required in the present study may have limited the ability to detect a significant relation. Based on the number of regressions examined, a conservative p-value (i.e., .013) was used in order to control for experiment-wise error. Although none of the proposed moderators were found to predict disordered eating, both EI and SYN as independent predictors nearly approached significance with p-values of .019 and .033, respectively. These findings are not considered significant based the necessity of controlling for experiment-wise error;
however, it would be worthwhile for scholars to continue to examine the potential protective function of positive cultural and gender identities within multidimensional models of disordered eating.

Also contrary to hypotheses, EI was not found to interact with ethnogender discrimination in predicting body image dissatisfaction. Thus, the hypothesis that EI would moderate the relation between ethnogender discrimination and body image dissatisfaction was not supported. Once again, as was the case with the additional proposed moderator variables, EI predicted lower levels of body image dissatisfaction, while ethnogender discrimination did not predict body image dissatisfaction.

Finally, when examined collectively, the proposed moderators (i.e., AC, SYN, EI) did not interact with ethnogender discrimination in predicting bulimic symptomatology or body image dissatisfaction. When bulimic symptomatology was examined as the criterion variable, ethnogender discrimination emerged as independent predictor, as was the case in the independent analyses. Interestingly, however, when body image dissatisfaction was examined as the criterion variable, of the three proposed moderators, only EI emerged as an independent predictor. The latter finding contrasted with the findings in the independent analyses in which all three proposed moderators independently predicted body image dissatisfaction. When examined concomitantly, EI was the only proposed moderator that emerged as independent predictor of body image dissatisfaction, supporting a fusion of ethnic and feminist identities. Based on these findings, it appears that ethnic and feminist identities are fused, with ethnic identity exerting a more powerful effect than positive feminist identity on body image
dissatisfaction. However, ethnic identity does not seem to be powerful enough to buffer the effect of discrimination on disordered eating or body image dissatisfaction.

In sum, the present study supported theorists’ predictions that ethnogender discrimination would predict bulimic symptomatology and that positive feminist identity and ethnic identity would predict body esteem. However, the hypotheses that positive feminist identity and ethnic identity would buffer the relations between ethnogender discrimination and bulimic symptomatology and ethnogender discrimination and body image dissatisfaction were not supported. In other words, despite previous empirical findings (e.g., Sabik & Tylka, 2006) and theoretical speculations (e.g., Striegel-Moore & Smolak, 1996) regarding the putative protective function of positive feminist and ethnic identities, the findings of the present study did not indicate that these variables serve a protective function against disordered eating or body image dissatisfaction in the face of discrimination.

These inconsistent findings are surprising for two reasons. First, the proposed moderators have been shown to be protective against other forms of psychological disturbances (e.g., Moradi & Subich, 2002; St. Louis & Liem, 2005) and have been conceptualized by scholars (e.g., Klonis, Endo, Crosby, & Worell, 1997; Phinney & Chavira, 1992) as adaptive forms of coping with sexist and racist discrimination. Second, previous research (e.g., Sabik & Tylka, 2006) has demonstrated that positive feminist identity buffers the sexist discrimination-disordered eating link. How, then, can these findings be reconciled?

First, the discrepancy with respect to other psychological disorders suggests that factors (e.g., EI) which are considered protective against other psychological disorders
may not generalize to ED symptomatology and body image dissatisfaction. This assertion reiterates the need to investigate protective factors of ED symptomatology, specifically. Second, it is possible, given the complex nature of disordered eating and the large number of factors that have been shown to increase risk for ED symptomatology, that the proposed moderators do interact with other predictors of disordered eating, and, thus, serve some protective function.

Third, the present study investigated ethnogender discrimination as a predictor of bulimic symptomatology and body image dissatisfaction. Based on the positive relations found between ethnogender discrimination and bulimic symptomatology and between the putative moderator variables (i.e., positive feminist identity, ethnic identity) and body image dissatisfaction, perhaps the model is slightly more complex than was initially proposed. For example, if ethnogender discrimination predicts higher levels of disordered eating and feminist and ethnic identities predict lower levels of body image dissatisfaction, perhaps feminist and ethnic identity serve a protective function against disordered eating in an indirect manner.

More specifically, since body image dissatisfaction predicts disordered eating and ethnic and feminist identities predict body esteem (i.e., low levels of body image dissatisfaction), perhaps the embracement of these identities protects African American women against body image dissatisfaction and, in turn, against disordered eating. Such a model would need to be empirically examined in order to understand how the proposed variables may combine and interact to predict disordered eating and body image dissatisfaction.
Fourth, it may also be the case that other variables moderate the relation between ethnogender discrimination and bulimic symptomatology. It would be worthwhile for researchers to explore additional theoretically relevant variables which may buffer the relation between discrimination and disordered eating. For example, perhaps self-esteem, a variable with ample empirical support as a protective factor against disordered eating and body image dissatisfaction, buffers the links between ethnogender discrimination and disordered eating. Furthermore, based on the positive relation that has been found in previous research (e.g., St. Louis & Liem, 2005) between self-esteem and ethnic identity, perhaps ethnic identity influences disordered eating and body image dissatisfaction indirectly through self-esteem.

Fifth, with regard to reconciling the difference between the current findings and previous findings which support feminist identity as a buffer between discrimination and disordered eating, the importance of examining predictors and protective factors for particular diverse groups is illuminated. Although positive feminist identity has been found to buffer the discrimination-disordered eating link among European American women, this hypothesis was not supported in the current study with African American women. These contradictory findings once again underscore the need to empirically examine relevant factors for particular diverse groups of women and emphasize the danger in assuming that research findings with predominantly White samples can be broadly applied to other groups.

Participants were given the opportunity to offer general feedback at the end of the survey and 63 participants chose to do so. The responses ranged from comments on the length or nature of the survey to more specific responses about a woman’s particular life
experience. The following responses provide valuable insight into the complexity of an individual’s experience with discrimination and the multiple identities many African American women embrace. For example, one woman responded by saying:

I think this is a wonderful survey. However, some of the questions were a little difficult for me because I am not only an African American woman who is discriminated against often – I am also discriminated against continuously because I am an African American woman who happens to be a mother (welfare queen issue) and a student (college kids are often discriminated against as well) and a lot of these different ‘classes’ go hand in hand with all the discrimination and lack of respect that I face.

Another woman responded with the following statement:

Growing up in probably one of the most racist cities in the country, I attribute most discrimination to race and not sex. Or honestly, I think I have gotten a lot of age discrimination. I think many stores, for example, hesitate on helping me because they may think I’m younger than I am and can’t afford what the store has to offer. But I can think of a time or two going to AutoZone or body shops not getting fast attention because ‘women know nothing about cars.’ But being in [a male dominated major] which is predominantly White males, it is hard for me to tell if it’s because I’m Black or female. Some do not listen to what I have to say. And finally, I am a lesbian and a ‘masculine’ female.

Regarding ethnic identity and the body image ideal, several comments were selected which illustrate the complexity of these constructs as well. One woman responded, “I have lighter skin but I identify as being Black. I sometimes find it hard to gain acceptance by other Black people because of it.” Another woman provided the following feedback:

When I was little I didn’t like who I was or how I looked. I am a dark-skinned, thin sista! But as I grew up, learned a little bit more about myself, culture, and my mother – that helped. I love myself now but it is hard when you are constantly shown on TV what is beautiful, what is expected, and how you are supposed to look. Even in our culture there is racism against each other!
Several other comments reflected the embracement of the “thick ideal.” For example, one woman replied:

To me, [focus on being fat or overweight] is a White woman thing. In today’s society Black women are trying to become more “thick” like the girls in the videos with slim waists and big butts. Most of the Black girls I know are trying to gain weight (like myself) to get the new video girl look, which is thicker women. A lot of Black women today are taking a lot of pride towards being thicker thanks to women like the comedian Nikki.

Another participant reiterated a similar sentiment regarding body image ideals. Her statement was as follows:

I think this is a great way to find out more information about Black women. Most black women, who grow up being socialized as Black women, and not White, are more likely to appreciate the curvy thickness of their figures. Most of the Black women I know wish their butts, chest, hips, and legs were bigger. Most of the men I know are attracted to women who are larger in these areas and smaller in the waist. Most White women I know have the opposite outlook on what body type should be like.

Finally, one woman’s response emphasized the importance of the social environment with regard to discrimination and also shed some light on the differential findings with regard to feminist identity as a protective factor for European American women as compared to African American women. Her response read as follows:

… I have seldom felt I was discriminated against because of the combination of being both Black and female, but if and when I have, it’s been purely because of being Black – period. Further, a lot of experiences in my life are very real and vivid memories, but my time and circumstances have changed. In the past, I might have worked in a different industry or in a different environment that made me more likely to be discriminated against. As time has gone on, I’ve been able to evolve into totally different work environments that lessen discrimination. For example, for the last 15 years, I have been in education. At times, I have been a… [job description removed to protect the anonymity of the participant]…and felt the very in your face, no holds barred, blatant racism of dealing with White students at a predominantly White institution. However, now I am in a… [job description removed]…role at a large urban school district where most of the employees, including the superintendent, are either female or Black, or both, predominantly. In this space and place, I have far fewer ‘opportunities’ to
experience racism, as it were. Another point is that as I’ve aged and matured, there is a certain level of personal power and confidence I’ve gained and I know that comes across to people and stops a lot of this crap cold. Which, in turn, brings up the issue of how much crap – sexist or racist – do confident versus unconfident people experience? People tend to pick their battles of whom to mess with – or not. Furthermore, a lot of stuff I just take to be the typical bad fall back behaviors that White folks will or can fall back into so I’m less shocked or offended or ticked off by what is just typical that is what you’ve come to expect when push comes to shove. If folks can be nice as long as they can be nice – fine. But if they flip out on you – NEXT; move on. Indeed, thanks for letting me know where you’re really coming from and thinking so I can cut bait and run. I don’t need or want to waste my time. Lastly, for a lot of my fellow African American women, we are very, very, very suspicious of and leery of the whole women’s lib – feminist thing; Audrey Lourde and bell hooks aside (and bell is much more about examination of culture more so than issues of gender). I have little sense of or desire for connection to a movement by, for, and about middle class, White women that at the end of the political day benefits middle and upper class White women far more than any other group of women of color and especially Black women.

The above statement seems to support the notion that self-esteem and/or the ability to externalize discrimination may serve a protective function against ethnogender discrimination. Furthermore, it is possible that the environment in which a woman works and lives may also impact her ability to cope with discrimination in adaptive ways. It would be worthwhile to explore what particular factors associated with different environments may allow women to externalize the experience of discrimination. Perhaps social support would buffer the discrimination-disordered eating link. Finally, the relevance of feminist identity for African American women deserves further attention.

Researchers (e.g., Moradi, 2005) have indicated that womanist identity may be a more relevant construct for African American women. Womanist identity refers to a model of gender identity development which is believed to apply to women across racial/ethnic, class and other diverse groups (Ossana, Helms, & Leonard, 1992) and emphasizes moving from an externally based definition of womanhood to a more
internally based self-definition as a woman (Moradi, 2005). Scholars (see Moradi, 2005) have asserted that womanist identity may better reflect gender identity development among African American women than do models of feminist identity. Further research is needed, however, in order to more fully understand and conceptualize this construct. Although it was of interest to the author to investigate this construct within the context of the present study, there is no instrument with strong psychometric properties currently available. Although the statements provided represent opinions and thoughts of a few select women from the sample, the feedback offers invaluable insight, nonetheless, regarding directions for future research.

5.3 Implications for future research

The findings of the present study indicate important directions for future research. First, the findings that ethnogender discrimination predicted bulimic symptomatology whereas the proposed moderator variables (i.e., AC, SYN, EI) did not predict bulimic symptomatology raise an important question for future research. What variables, then, might moderate this relation? When considering previous research which indicates that African American women continue to experience high levels of discrimination (e.g., Landrine & Klonoff, 1996), the findings of the current study which indicate that over 95% of the sample experienced at least some level of discrimination, and the current findings that discrimination predicts bulimic symptomatology, it seems plausible that other variables may buffer the relation between discrimination and disordered eating. One theoretically relevant variable that would be worthwhile to explore as a moderator in future research is self-esteem.
In support of this assertion, Corning (2002) investigated whether self-esteem moderated (i.e., strengthened) the relation between perceived sexist discrimination and symptoms of depression, anxiety, and somatization among a sample of predominantly European American undergraduate women. Her findings indicate that personal self-esteem moderated the relation between perceived sexist discrimination and depression. Specifically, for those women with low levels of personal self-esteem, depression increased with perceived sexist discrimination. However, as personal self-esteem increased, the effect of perceived sexist discrimination on depression decreased.

Additional support for the moderating effect of self-esteem on discrimination and psychological distress was provided by Moradi and Subich’s (2004) findings in which self-esteem moderated (i.e., buffered) the relation between sexist events and general psychological distress. In order to extend these findings, researchers could explore whether self-esteem also moderates the relation between ethnogender discrimination and disordered eating among African American women.

Moreover, perhaps particular forms of coping with discrimination are salient with respect to resilience against ED symptomatology and body image dissatisfaction among African American women. Perhaps particular forms of coping, such as the ability to generate alternatives when faced with problematic circumstances, increase a woman’s resilience to engaging in disordered eating patterns, even in the face of discrimination. Theoretically, if women use certain disordered eating behaviors as a means of emotional catharsis (Stice & Shaw, 2002) or numbing, perhaps the ability to generate alternatives to disordered eating patterns would enable women to cope more effectively with discrimination, and in turn, would increase resilience. Furthermore, based on recent
research (e.g., Hund & Espelage, 2005) which implicates alexithymia (i.e., difficulty identifying and articulating emotions) as an important mediator between previous traumas (e.g., childhood sexual abuse) and disordered eating and the conceptualization of discrimination as another form of trauma in the lives of women of color, it would be worthwhile to explore whether emotional awareness increases resilience to disordered eating, even in the face of ethnogender discrimination.

Social support, which has also received attention in the eating disorders literature, is another theoretically relevant variable which may buffer the discrimination-disordered eating/body image dissatisfaction links. Indeed, previous research (e.g., Shorter-Gooden, 2004) has supported the assertion that social support is an adaptive way in which African American women cope with the effects of discrimination. Future research examining the impact of various forms of coping on discrimination and ED symptomatology could provide important information regarding protective factors of disordered eating and body image dissatisfaction among African American women.

It would also be worthwhile to examine whether body esteem moderates the relation between ethnogender discrimination and disordered eating in future research. The current study examined body image dissatisfaction as a criterion variable, whereas future research could examine body esteem (i.e., body image satisfaction) as a buffer between discrimination and disordered eating patterns. Further research is needed in order to determine whether additional theoretically variables moderate the link between ethnogender discrimination and ED symptomatology.

With regard to the unexpected findings with respect to ethnic identity, it is possible that ethnic identity indirectly protects African American women against
disordered eating and correlates of disordered through one of the aforementioned variables (e.g., self-esteem). For example, perhaps high levels of ethnic identity predict self-esteem which, in turn, predicts lower levels of disordered eating and body image dissatisfaction. Such findings were demonstrated in Phan and Tylka’s (2006) research with Asian American women. Thus, it would be worthwhile to explore these variables in conjunction in future research with African American women and other women of color.

Second, based on the findings of the current study indicating that 1) discrimination predicts bulimic symptomatology but does not predict body image dissatisfaction and 2) high levels of ethnic identity and feminist identity predict lower levels of body image dissatisfaction but do not predict lower levels of bulimic symptomatology, it would be worthwhile to explore additional predictor variables (e.g., pressure for thinness) in conjunction with discrimination, multiple identities, body image dissatisfaction, and disordered eating. Such an investigation would address scholars’ (e.g., Kashubeck-West & Mintz, 2001; Kawamura, 2002; Root, 1990, 2001; Striegel-Moore & Cachelin, 1999) calls to conduct multiple-predictor examinations aimed at understanding the multidimensional nature of disordered eating and body image dissatisfaction among women of color.

Researchers (e.g., Kawamura, 2002) in the eating disorders literature have emphasized the importance of examining how variables work together to predict ED symptomatology among women of color. Such an investigation would address this gap in the literature. In order to extend the findings of the current study, it would be worthwhile to examine how variables such as pressure for thinness, internalization of the thin-ideal stereotype, and self-esteem, which have solid empirical support in predicting
ED symptomatology among Caucasian American women, work in conjunction with culturally relevant variables such as ethnogender discrimination, womanist identity, and ethnic identity in predicting disordered eating and body image dissatisfaction among African American women.

Third, several women in the current study commented on the significance of skin tone (i.e., light skin tone, dark skin tone) and self acceptance/community acceptance. Another direction for future research would be to examine the importance of skin tone satisfaction, community acceptance, discrimination and the impact on body image satisfaction and disordered eating. It is possible, for example, that if a woman identifies strongly with African American culture but concomitantly experiences a lack of acceptance from her community based on her skin tone, ethnic identity may be less powerful in protecting against eating disorder symptomatology and other forms of psychological distress. Previous research (e.g., Falconer & Neville, 2000) suggests that satisfaction with skin color predicts greater body image satisfaction. Accordingly, it would behoove researchers to include skin color satisfaction in disordered eating models among African American women.

Fourth, several responses from women in the current study reiterate criticisms from scholars (e.g., Downing & Roush, 1985; Moradi, Subich, & Phillips, 2002; Vandiver, 2002) regarding the relevance of feminist identity among African American women. The construct of feminist identity has been thought to be more relevant to the experiences of European American women than to those of women of color. Moreover, identity development models such as feminist identity have been criticized for reflecting
a singular perspective on identity that does not include the complex reality of the lives of those individuals who belong to more than one subordinated group (Moradi, 2005; Reynolds & Pope, 1991).

Womanist identity, a model of gender identity development conceptualized by Helms (cited in Carter & Parks, 1996), is believed to be a more culturally relevant model of identity for women of diverse ethnic, socioeconomic and other oppressed groups (Ossana, Helms, & Leonard, 1992) than are more traditional models of feminist identity. Unfortunately, the development of this construct is still in its infancy. Although scholars have worked to create an instrument reflecting this construct, an instrument with strong psychometric properties has not yet been developed.

Researchers (e.g., Moradi, 2005) have underscored the importance of scholarly efforts aimed at rearticulating and refining the womanist identity development model and extending these findings into development of a strong psychometric instrument that measures this construct. Scholars (e.g., Moradi, 2005) have suggested that models of womanist identity development have the potential to extend beyond a single aspect of identity to include various aspects of women’s identities (e.g., race/ethnicity, class, sexual orientation). Efforts aimed at further articulating and refining the construct of womanist identity could extend the results of the current study. More specifically, an investigation of womanist identity as a moderator between discrimination and disordered eating and correlates of disordered eating would provide valuable information to researchers and practitioners regarding potential protective factors of ED symptomatology among African American women.
Finally, according to Barron and Kenny (1986), moderating effects are difficult to detect due the nature of the analysis (i.e., HMR) required. Moreover, the large number of interactions examined in the current study required the implementation of a conservative alpha level to determine significance, which compounds the difficulty in detecting moderating effects. It is possible, therefore, that moderating effects of the proposed variables were not detected. Thus, replicating the findings of the current study in future research would be informative. Generally speaking, it would behoove researchers to continue investigating predictive and protective factors of EDs and ED symptomatology in order to extend our knowledge about risk, resilience, and prevention among African American women and other women of color.

5.4 Implications for practice and prevention

The findings of the present study have important implications for practice and prevention. Although the primary hypotheses that positive feminist and ethnic identities would buffer the relations between ethnogender discrimination and bulimic symptomatology and ethnogender discrimination and body image dissatisfaction were not supported, the relations found between the examined variables provide essential information for practitioners.

First, the present study supports previous findings and contributes to the extant literature which has challenged myths that African American women are invulnerable to ED symptomatology and body image dissatisfaction. Although only approximately one to three percent of the participants in the current study were classified as bulimic (i.e., those with average scores above 3.7 and 3.0, respectively\(^1\)), which parallels the lifetime

\(^1\) Total score cut-offs recommended by Thelen and Smith (1994) converted to average scores
prevalence of bulimia nervosa among women documented in the DSM-IV (American Psychiatric Association, 1994), approximately 54% endorsed at least some bulimic symptomatology (i.e., average scores of 1.5 or higher\(^2\)). In line with these findings, scholars (e.g., Harris & Kuba, 1997; Rand & Kulda, 1990) have asserted that women of color do indeed suffer from compulsive eating disturbances or other forms of eating disorder symptomatology that do not meet criteria set forth in the DSM-IV (American Psychiatric Association, 1994). Furthermore, approximately 8% endorsed some body image dissatisfaction (i.e., those participants with an average score greater than 3; 3 indicating neutral, 4 indicating slightly dislike, 5 indicating strongly dislike).

Accordingly, it is imperative that practitioners carefully and rigorously assess for various forms of eating disturbance and body image concerns with their African American female clients.

Second, the finding that ethnogender discrimination predicts bulimic symptomatology in conjunction with previous findings regarding the relation between discrimination and general psychological distress represents an important contribution to the research literature and underscores the pervasive negative impact of discrimination on the well-being of African American women. These findings illustrate the importance of assessing for experiences of discrimination with African American clients as these clients appear to be at higher risk for general psychological distress and disordered eating.

Third, previous assumptions that a strong sense of ethnic identity and/or feminist identity would buffer the relation between ethnogender discrimination and bulimic

\(^2\) The average score used to define some bulimic symptomatology was self-generated by examining the individual items of the BULIT-R. It was determined that those individuals who scored an average of 1.5 or higher could be classified as endorsing at least some symptomatology.
symptomatology were not supported in the current study. In fact, none of the proposed moderators were significantly related to bulimic symptomatology. Accordingly, practitioners should not assume that African American women who endorse a strong sense of ethnic and/or feminist identity are protected against disordered eating. It would behoove practitioners to consider and enhance, in therapy, additional adaptive traits which may buffer this relation. For example, in related research, scholars (e.g., Corning, 2002; Moradi & Subich, 2004) have found that self-esteem buffers the relation between experiences of discrimination and depression/general psychological distress. Accordingly, targeting self-esteem in therapy would be a relevant intervention.

Although empirical evidence is needed in order to determine whether self-esteem moderates the discrimination-disordered eating link, it appears important to focus on enhancing self-esteem in African American female clients as this variable appears to buffer against the experiences of discrimination and other forms of psychological distress. Indeed, scholars have suggested that women with high levels of self-esteem are likely more adept at dismissing potentially damaging interpersonal experiences (e.g., ethnogender discrimination) than are women who hold more uncertain or negative views of themselves (e.g., Moradi & Subich, 2004).

Moreover, ethnogender discrimination reflects individuals’ perceptions that they have been discriminated against based on race/ethnicity and gender. Accordingly, it would behoove practitioners to examine how clients interpret and cope with discriminatory events. Indeed, disordered eating behaviors have been conceptualized as a means of coping with distress for African American women (Thompson, 1996). If practitioners are able to help clients identify adaptive ways to cope with ethnogender
discrimination then clients may be less likely to engage in disordered eating as a means of coping with discrimination-associated distress.

Theoretically (Landrine & Klonoff, 1996) ethnogender discrimination leads to psychological distress and disordered eating when clients internalize these messages as an indication of something inherently wrong with their core selves. Practitioners may assist their African American female clients by teaching them to externalize these events. For example, helping clients to recognize the distorted nature of racist/sexist messages by using cognitive techniques such as restructuring/reframing and/or reality-testing may allow them to externalize such events as resulting from institutionalized ignorance rather than reflecting negative aspects of themselves. Indeed, scholars have argued that making external attributions about racism/sexism rather than internal attributions may serve a protective function against psychological distress (e.g., Crocker & Major, 1989; Moradi & Subich, 2004).

Fourth, scholars (e.g., Shorter-Gooden, 2004) have suggested that obtaining social support is another adaptive form of coping with the distress associated with discrimination. Accordingly, practitioners may facilitate and encourage clients to seek additional social support in order to cope with experiences of discrimination. For example, therapy groups for women of color may be an additional safe place in which women can disclose their concerns and gain support in a therapeutic environment. If therapy groups are not available, therapists could encourage and assist their clients in creating their own support groups with other women of color in their respective communities (e.g., college campuses). Generally speaking, examining coping strategies that clients utilize to manage their experiences with discrimination and providing
additional adaptive coping methods would likely benefit clients who experience psychological distress associated with discriminatory experiences.

Fifth, the findings of the current study indicate that, in addition to ethnogender discrimination, BMI and body image dissatisfaction predict bulimic symptomatology. Accordingly, therapeutic interventions aimed at increasing positive body esteem may prove beneficial for African American women clients who are at risk for disordered eating behaviors. Furthermore, the findings which indicate that positive ethnic and feminist identities predict lower levels of body image dissatisfaction (i.e., higher levels of body esteem) indicate points of therapeutic emphasis regarding increasing body esteem. Specifically, as body image dissatisfaction predicts disordered eating and positive ethnic/feminist identities predict body esteem, facilitating a positive identification with an individual’s multiple identities may indirectly protect African American women against disordered eating through body esteem. Practitioners may intervene at the level of body image dissatisfaction in order to prevent disordered eating behaviors. Essentially, by facilitating an embracement of personal identities, practitioners may directly improve body esteem and indirectly reduce ED symptomatology. Overall, practitioners would be well-advised to incorporate a comprehensive approach to treatment by focusing not only on symptomatology, but also on facilitating the development and enhancement of clients’ positive characteristics and strengths.

Finally, the deleterious consequences of discrimination on the psychological well-being of African American women cannot be overstated. Not only has research supported the negative impact of discrimination on general psychological distress, but the current study, along with other studies (e.g., Corning, 2002), supports the impact of
discrimination on specific forms of symptomatology (e.g., bulimic symptomatology, depression). These findings emphasize the importance of systemic interventions aimed at reducing multiple forms of discrimination and raising awareness about disordered eating and body image dissatisfaction among women of color. Indeed, the present study’s findings support Thompson’s (1996) assertion that prevention of disordered eating and correlates of eating disordered symptomatology depends not solely on individual healing but also on changing the social and environmental conditions that underlie their etiology.

Implementations of prevention programs that directly address and combat discriminatory messages are imperative. Specifically, educating individuals about the detrimental effects that racist and sexist discrimination can have on various aspects of psychological health would be beneficial. Based on the findings in the research literature (e.g., Mintz & Betz, 1988; Tylka & Subich, 2002) documenting the high prevalence of ED symptomatology among college women, college campuses seem to be an appropriate and relevant venue for promotion of educational and prevention programs. Counselors on college campuses may implement outreach efforts directed at various student services offices (e.g., academic advising, student health centers) on campus in order to educate individuals in the campus community about the multiple deleterious consequences of discrimination including ED symptomatology.

Furthermore, it would be beneficial to target African American organizations in order to de-stigmatize seeking mental health services, increase awareness of the psychological distress associated with discrimination, provide education about the reality of disordered eating and body image dissatisfaction in the African American community, and offer and encourage social support. Encouraging the development of support/therapy
groups for women of color is a specific avenue through which professionals could direct their prevention efforts.

5.5 **Limitations of the study**

Limitations of the current study need to be addressed. First, as with any study that utilizes self-report measures exclusively, its findings may be susceptible to selective or erroneous reporting. As is the case in eating disorder research in general, the shame attached to acknowledgment of eating disordered behavior may have influenced participants to answer dishonestly to the items used to assess this construct, despite explicit requests that they answer honestly. Similarly, the potential social desirability attached to endorsing high levels of body esteem (i.e., low levels of body image dissatisfaction) may have overwhelmed the participants’ willingness to answer the items truthfully. Indeed, only approximately 8% of the sample endorsed some level of body image dissatisfaction. Future research may control for this potential problem with the inclusion of a social desirability and/or careless responding measure.

Second, the instrument used to measure ethnogender discrimination assessed the participants’ *perceptions* of discrimination to which they have been subjected and, thus, does not necessarily measure *actual* levels of discrimination. Although over 95% percent of the sample endorsed experiencing at least one discriminatory event “once in awhile” in the past year, only 4.6% endorsed experiencing high levels of ethnogender discrimination (i.e., average score of 3.5 or higher; 3 indicating some sometimes, 4 indicating a lot, 5 indicating most of the time, 6 indicating almost all of the time). While the scores on this self-report measure likely contain variance due to actual levels of discrimination experienced, scores may also be confounded with other personal factors (e.g., lower level
of awareness, earlier identity stages). In other words, an individual with a lower level of awareness may not perceive unfair treatment as a reflection of discrimination even if she is subjected to discriminatory events. Moreover, the participants’ perceptions of this variable may or may not be an accurate reflection of actual frequency of discrimination that they experienced based on race/gender. Indeed, several women indicated that it is difficult to determine whether they are being treated unfairly based on race, gender or other variables (e.g., age, class).

Another limitation with respect to the instrument utilized to measure ethnogender discrimination is its potential lack of sensitivity. The anchors for response choice are “never happened” to “happened almost all of the time” which doesn’t tap the intensity of experience with ethnogender discrimination. For example, although a participant may endorse an item such as “I have been made fun of, picked on, pushed, shoved, hit, or threatened with harm because I am an African American woman” only “once in awhile” in the past year, such an experience may have tremendous impact on psychological distress; however this would not be reflected in her total score. Based on the large number of regressions already included the present study, it was not advisable to include a subscale measuring appraisal of stress (such as that which is included in the Schedule of Racist Events) associated with discriminatory events; however it would be worthwhile in future research to include an appraisal of stress subscale in order to more comprehensively measure the impact of experiences with discrimination.

A third limitation is the fact that a significant relation was found between the predictor and one proposed moderator (i.e., active commitment) within the data which presents issues of multicollinearity. As recommended by Barron and Kelly (1986) the
variables were centered in order to reduce multicollinearity; however it is unclear how effective this procedure is in reducing this problem.

Fourth, it is not clear whether the lack of significance found in the regression analyses performed is attributable to the inadequacy of the moderator hypotheses or to the questionable validity of the instruments used. For example, scholars have questioned the utility of the feminist identity construct among women of color and have suggested that womanist identity may be a more adequate construct in understanding gender identity among African American women. Illustrative of this speculation was the aforementioned perspective of one participant in the current study in which she indicated a rejection of the “women’s movement” as inclusive of women of color. Currently, however, the construct of womanist identity is still being refined and an instrument reflective of this construct with strong psychometric properties is not yet available. The findings of the present study underscore the need for further development of a culturally relevant construct of gender identity.

Fifth, the findings of the current study are specific to bulimic symptomatology and are, therefore, not generalizable to other categories of disordered eating (e.g., anorexia nervosa, eating disorder not otherwise specified). Although the current study investigated bulimic symptomatology specifically based on theoretical speculations and empirical findings that this particular cluster of ED symptoms is most relevant to African American women, the entire spectrum of disordered eating behaviors was not examined. It would behoove researchers to examine similar models of discrimination and multiple identities with more comprehensive measures of ED symptomatology.
A sixth limitation of this study is the skewness of distribution on most of the examined variables. For example, although over 95% of the sample endorsed experiencing at least one event of ethnogender discrimination “once in awhile” in the past year, only approximately 4% endorsed frequent experiences with ethnogender discrimination (i.e., those participants with total scores of 3.5 or higher; 3 indicating sometimes, 4 indicating a lot, 5 indicating most of the time, 6 indicating almost all of the time). Conversely, approximately 80% of the sample endorsed slight to strong endorsement of ethnic identity (i.e., those participants with total scores of 3 or higher; 3 indicating somewhat agree, 4 indicating strongly agree). Similarly, approximately 68% endorsed mild to strong endorsement of active commitment and an overwhelming 97% endorsed mild to strong endorsement of synthesis (i.e., those participants with total scores of 3.5 or higher; 3 indicating neither agree nor disagree, 4 indicating mildly agree, 5 indicating strongly agree) indicating mild to strong endorsement of a positive feminist identity. In addition, only approximately 8% endorsed body image dissatisfaction with approximately 54% endorsing at least some bulimic symptomatology.

One of the primary research questions of the present study was to determine which variables may protect African American women from bulimic symptomatology and body image dissatisfaction, despite frequent experiences with ethnogender discrimination. The small number of participants who endorsed perceiving high levels of discrimination, body image dissatisfaction, and bulimic symptomatology in conjunction with the large number of participants who endorsed slight to strong ethnic and feminist identity reflects a restriction in range and, thus, may have limited the power to detect a moderating effect.
Finally the demographics of the sample were a limitation of this study. Practical considerations prevented the inclusion of representative numbers of individuals from diverse backgrounds with respect to age and socioeconomic status. The majority of the participants were young (90% were 31 years of age or younger) undergraduate college students (82%), and identified as middle (49%) or working class (36%). Findings of this study, therefore, are not generalizable to older African American women, adolescents, African American women not in college, African American men, African American women from upper-middle to upper class backgrounds, or other women of color.

5.6 Conclusion

The present study sought to address a major gap in the eating disorders literature by examining predictive and protective factors of ED symptomatology and body image dissatisfaction among African American women. The importance of addressing this gap by integrating population-specific risk (e.g., discrimination) and protective factors (e.g., positive cultural identity) has been emphasized by numerous researchers in the field (e.g., Moradi, Dirks, & Matteson, 2005; Striegel-Moore & Cachelin, 2001).

The major objectives of this study were threefold: 1) to investigate whether ethnogender discrimination predicts bulimic symptomatology and body image dissatisfaction 2) to determine whether three theoretically relevant variables (i.e., AC, SYN, EI) would buffer the ethnogender discrimination-bulimic symptomatology and ethnogender discrimination-body image dissatisfaction relations, and based on these findings 3) to lay groundwork for the construction of a culturally relevant model of resilience to disordered eating and body image dissatisfaction among African American women. The intent was to expand the extant literature regarding the impact of
discrimination on disordered eating and body image dissatisfaction among African American women and to identify factors that may protect these women against eating disordered behavior, body image dissatisfaction, and the related deleterious psychological effects.

Although none of the proposed protective factors (i.e., AC, SYN, EI) emerged as moderators between the proposed predictor and criterion variables, ethnogender discrimination was found to predict bulimic symptomatology and all three proposed moderator variables were found to predict body esteem. Furthermore, 8% of the sample endorsed some level of body image dissatisfaction and approximately 54% endorsed at least some bulimic symptomatology. The present study contributes to the extant literature with regard to debunking myths that African American women are invulnerable to body image dissatisfaction and ED symptomatology. The findings of the present study also contribute to extant literature with regard to the impact of discrimination on bulimic symptomatology as well as the importance of ethnic identity and feminist identity to body esteem.

Because this study is among the first to explore the impact of discrimination on disordered eating and body image dissatisfaction in conjunction with an examination of putative protective factors, there is clearly much to learn about which additional factors contribute to resilience against ED symptomatology and body image dissatisfaction among African American women. Future investigations into protective factors are strongly encouraged. This knowledge could be used to understand how resilience applies to disordered eating and body image dissatisfaction and eventually could be utilized to construct multidimensional models of resilience among African American women.
Such an extension of the research literature is particularly relevant for counseling psychologists, as they seek to enhance clients’ strengths, as opposed to focusing solely on their weaknesses (Gelso & Fretz, 2001). Enhancing our knowledge regarding resilience against EDs and ED symptomatology will channel new energy into treatment and preventative efforts and will provide much needed knowledge regarding which variables are salient in risk and resilience to disordered eating and its correlates among African American women. As our knowledge extends regarding resilience among diverse groups, professionals will be better equipped to assist their clients by focusing not only on counteracting risk factors for EDs and ED symptomatology, but on cultivating and enhancing protective factors (e.g. internal strengths) as well.

Importantly, as research accrues in this area, professionals will have at their disposal models of disordered eating that are relevant to individuals from culturally diverse backgrounds. Scholars (e.g., Moradi et al., 2005) have emphasized that the paucity of research on disordered eating and correlates of eating disordered behavior among women of color prevents clear conclusions from being drawn regarding predictors and protective factors for women from culturally diverse groups. In order to deliver culturally relevant treatment and prevention programs to diverse groups, the paucity of information in the research literature must be addressed. The present study provides one step in addressing this gap.
APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE
INSTRUCTIONS: Please enter the information that best describes you.

1. I am currently enrolled in Psychology 100 at The Ohio State University and am completing this study for course credit.
   Yes ________ No ________
   If you answered yes to the above question please enter your code number provided to you by the researcher here: ________

2. Age: ________

3. Ethnic identification:
   African American ___
   Biracial _____
   Other (please specify) ____________________

4. Relationship status:
   Single ______
   Long-term relationship_____
   Married _____
   Divorced ____
   Other (please specify) ____________________

5. Year in School
   Freshman or high school senior ____
   Sophomore ________
   Junior ______
   Senior ______
   Post-bac ____
   Graduate student ___
   Other (please specify) ____________________

6. Socio-economic identification
   Upper class ______
   Upper-middle class _______
   Middle class ______
   Working class ______

7. Type of college/university you are currently attending
   Historically Black college/university ______
   Predominantly White institution ______

8. Date of birth ________
APPENDIX B

SCHEDULE OF SEXIST EVENTS - RECENT (SSE-R)
INSTRUCTIONS: The following questionnaire will ask you about your experiences as a WOMAN. Please think carefully about your experiences as you answer the questions below. Read the response choices carefully, and answer each question by thinking about what your experiences as a WOMAN in the PAST YEAR have been like. Please answer the questions based on your gender using the following rules:

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

How many times have you been treated unfairly by teachers or professors because you are a woman?
1. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by your employer, boss, or supervisors because you are a woman?
2. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are a woman?
3. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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?
4. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by strangers because you are a woman?
5. How many times IN THE PAST YEAR? 1 2 3 4 5 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?
6. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by neighbors because you are a woman?
7. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by your boyfriend, husband, or other important man in your life because you are a woman?
8. How many times IN THE PAST YEAR? 1 2 3 4 5 6
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?

9. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you been treated unfairly by your family because you are a woman?

10. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have people made inappropriate or unwanted sexual advances to you because you are a woman?

11. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have people failed to show you the respect you deserve because you are a woman?

12. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you wanted to tell someone off for being sexist?

13. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you been really angry about something sexist that was done to you?

14. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

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?

15. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you been called a sexist name like bitch, cunt, chick, or other names?

16. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you gotten into an argument or a fight about something sexist that was said or done to you or done to somebody else?

17. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are a woman?

18. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6

How many times have you heard people making sexist jokes or degrading sexual jokes?

19. How many times **IN THE PAST YEAR**? 1  2  3  4  5  6
How different would your life have been now if you **HAD NOT BEEN** treated in a sexist and unfair way?

20. **IN THE PAST YEAR:**

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<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>Same as now</td>
<td>Little different</td>
<td>Different in many ways</td>
<td>Different in a lot of ways</td>
<td>Different in most ways</td>
<td>Totally different</td>
<td></td>
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APPENDIX C

SCHEDULE OF RACIST EVENTS – RECENT (SRE-R)
INSTRUCTIONS: We are also interested in your experiences with racism. As you answer the questions below, please think about your experience with racism in the PAST YEAR. For each question, please indicate the number that best captures the things that have happened to you. Please answer the following questions based on your experience as an African American using the following rules:

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

How many times have you been treated unfairly by teachers or professors because you are Black?
1. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by your employer, boss, or supervisors because you are Black?
2. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are Black?
3. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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 Black?
4. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by strangers because you are Black?
5. How many times IN THE PAST YEAR? 1 2 3 4 5 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 Black?
6. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by neighbors because you are Black?
7. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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 you are Black?
8. How many times IN THE PAST YEAR? 1 2 3 4 5 6
How many times have you been treated unfairly by people you thought were your friends because you are Black?

9. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

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 you are Black?

10. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

How many times have people misunderstood your intentions and motives because you are Black?

11. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

How many times have you wanted to tell someone off for being racist but didn’t say anything?

12. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

How many times have you been really angry about something racist that was done to you?

13. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

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?

14. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

How many times have you been called a racist name like n____, coon, jungle bunny or other names?

15. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

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?

16. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are Black?

17. How many times **IN THE PAST YEAR?** 1  2  3  4  5  6

**How different would your life have been now if you HAD NOT BEEN** treated in a racist and unfair way?

18. **IN THE PAST YEAR:**

<table>
<thead>
<tr>
<th>Same as</th>
<th>Little different</th>
<th>Different in many ways</th>
<th>Different in a lot of ways</th>
<th>Different in most ways</th>
<th>Totally different</th>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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APPENDIX D

ETHNOGENDER DISCRIMINATION SCALE (EDS)
INSTRUCTIONS: The following questions will ask you about your experience as an AFRICAN AMERICAN WOMAN. Please think carefully about your life as you answer the questions below. For each question, read the question and then answer it twice: answer once for what your ENTIRE LIFE (from when you were a child to now) has been like, and once for what the PAST YEAR has been like. Mark your answers on the scales provided, using these rules:

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

How many times have you been treated unfairly by teachers or professors because you are an **African American woman**?

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<tr>
<th>Question</th>
<th>Entire Life</th>
<th>Past Year</th>
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<td>1.</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
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<td>2.</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
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How many times have you been treated unfairly by your employer, boss, or supervisors because you are an **African American woman**?

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<tr>
<th>Question</th>
<th>Entire Life</th>
<th>Past Year</th>
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<td>3.</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
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<td>4.</td>
<td>1 2 3 4 5 6</td>
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How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are an **African American woman**?

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<th>Question</th>
<th>Entire Life</th>
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<td>1 2 3 4 5 6</td>
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<td>6.</td>
<td>1 2 3 4 5 6</td>
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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 an **African American woman**?

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<th>Question</th>
<th>Entire Life</th>
<th>Past Year</th>
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<td>7.</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
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<td>8.</td>
<td>1 2 3 4 5 6</td>
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How many times have you been treated unfairly by strangers because you are an **African American woman**?

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<th>Question</th>
<th>Entire Life</th>
<th>Past Year</th>
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<td>9.</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
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<td>10.</td>
<td>1 2 3 4 5 6</td>
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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 an **African American woman**?

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<th>Question</th>
<th>Entire Life</th>
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<td>12.</td>
<td>1 2 3 4 5 6</td>
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How many times have you been treated unfairly by neighbors because you are an African American woman?

13. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
14. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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 an African American woman?

15. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
16. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have people made inappropriate or unwanted sexual advances to you because you are an African American woman?

17. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
18. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have people failed to show you the respect you deserve because you are an African American woman?

19. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
20. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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 you are an African American woman?

21. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
22. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been treated unfairly by people you thought were your friends because you are an African American woman?

23. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
24. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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 you are an African American woman?

25. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
26. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have people misunderstood your intentions and motives because you are an African American woman?

27. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
28. How many times IN THE PAST YEAR? 1 2 3 4 5 6
How many times have you wanted to tell someone off for being racist and/or sexist?
29. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
30. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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

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 and/or sexist thing that was done to you?
33. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
34. How many times IN THE PAST YEAR? 1 2 3 4 5 6

How many times have you been called a racist and/or sexist name?
35. How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
36. How many times IN THE PAST YEAR? 1 2 3 4 5 6

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

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

How different would your life have been now if you HAD NOT BEEN treated in a sexist, racist and unfair way?
41. THROUGHOUT YOUR ENTIRE LIFE:

1 2 3 4 5 6
Same as Little Different in Different in Different in Totally
now different many ways a lot of ways most ways different
42. IN THE PAST YEAR:

1 2 3 4 5 6
Same as Little Different in Different in Different in Totally
now different many ways a lot of ways most ways different
APPENDIX E

FEMINIST IDENTITY COMPOSITE (FIC)
**INSTRUCTIONS:** For each item, please choose the answer that best characterizes your attitudes or behaviors.

1. I don’t see much point in questioning the general expectation that men should be masculine and women should be feminine.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

2. One thing I especially like about being a woman is that men will offer me their seat on a crowded bus or open doors for me because I am a woman.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

3. I like being a traditional female.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

4. I think that men and women had it better in the 1950’s when married women were housewives and their husbands supported them.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

5. If I were married to a man and my husband was offered a job in another state, it would be my obligation to move in support of his career.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

6. I think that most women will feel most fulfilled by being a wife and mother.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree

7. I think it’s lucky that women aren’t expected to do some of the more dangerous jobs that men are expected to do, like construction work or race car driving.
   - 1 Strongly disagree
   - 2 Mildly disagree
   - 3 Neither agree nor disagree
   - 4 Mildly agree
   - 5 Strongly agree
8. Gradually, I am beginning to see just how sexist society really is.

   | 1  | 2  | 3  | 4  | 5  |
   |---------------------------|
   | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

9. I feel angry when I think about the way I am treated by men and boys.

   | 1  | 2  | 3  | 4  | 5  |
   |---------------------------|
   | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

10. Men receive many advantages in society and because of this are against equality for women.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

11. I never realized until recently that I have experienced oppression and discrimination as a woman in this society.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

12. I feel like I’ve been duped into believing society’s perceptions of me as a woman.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

13. My female friends are like me in that we are all angry at men and the ways we have been treated as women.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

14. In my interactions with men, I am always looking for ways I may be discriminated against because I am female.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

15. Regretfully, I can see ways in which I have perpetuated sexist attitudes in the past.

    | 1  | 2  | 3  | 4  | 5  |
    |---------------------------|
    | Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |
16. I am very interested in women writers.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

17. I am very interested in women musicians.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

18. I am very interested in women artists.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

19. I am very interested in women’s studies.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

20. I feel like I have blended my female attributes with my unique personal qualities.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

21. I am proud to be a competent woman.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

22. I have incorporated what is female and feminine into my own unique personality.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

23. I enjoy the pride and self-assurance that comes from being a strong female.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

24. As I have grown in my beliefs I have realized that it is more important to value
    women as individuals than as members of a larger group of women.
   
   1 2 3 4 5
   Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree
25. I am very committed to a cause that I believe contributes to a more fair and just world for all people.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

26. I want to work to improve women’s status.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

27. I am willing to make certain sacrifices to effect change in this society in order to create a nonsexist, peaceful place where all people have equal opportunities.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

28. It is very satisfying to me to be able to use my talents and skills in my work in the women’s movement.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

29. I care very deeply about men and women having equal opportunities in all respects.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

30. I choose my “causes” carefully to work for greater equality for all people.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

31. I feel that I am a very powerful and effective spokesperson for the women’s issues I am concerned with right now.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree

32. On some level, my motivation for almost every activity I engage in is my desire for an egalitarian world.

1 2 3 4 5
Strongly Mildly Neither agree Mildly Strongly
disagree disagree nor disagree agree agree
33. I owe it not only to women but to all people to work for greater opportunity and equality for all.

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Please answer “mildly disagree” for this item (validity check)

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APPENDIX F

THE MULTIGROUP ETHNIC IDENTITY MEASURE (MEIM)
Note: Items 1-3, 5-6, 8R, 10R, 11-14, 16, 18, and 20 represent the ethnic identity subscale.

**INSTRUCTIONS:** In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or *ethnic groups* that people come from. Some examples of the names of ethnic groups are Mexican-American, Hispanic, Black, Asian-American, American Indian, Anglo-American, and White. Every person is born into an ethnic group, or sometimes two groups, but people differ on how important their *ethnicity* is to them, how they feel about it, and how their behavior is affected by it. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it. Please answer the following questions based on your identification as African American/Black.

Please indicate how much you agree or disagree with each statement below.

1. I have spent time trying to find out more about my own ethnic group, such as its history, traditions, and customs.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

2. I am active in organizations or social groups that include mostly members of my own ethnic group.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

3. I have a clear sense of my ethnic background and what it means to me.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

4. I like meeting and getting to know people from ethnic groups other than my own.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

5. I think a lot about how my life will be affected by my ethnic group membership.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

6. I am happy that I am a member of the group I belong to.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

7. I sometimes feel it would be better if different ethnic groups didn’t try to mix together.

   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree
8. I am not very clear about the role of my ethnicity in my life.
   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

9. I often spend time with people from ethnic groups other than my own.
   1   2   3   4
   Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

10. I really have not spent much time trying to learn more about the culture and history of my ethnic group.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

11. I have a strong sense of belonging to my own ethnic group.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

12. I understand pretty well what my ethnic group membership means to me, in terms of how to relate to my own group and other groups.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

13. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

14. I have a lot of pride in my ethnic group and its accomplishments.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

15. I don’t try to become friends with people from other ethnic groups.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

16. I participate in cultural practices of my own group, such as special food, music, or customs.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

17. I am involved in activities with people from other ethnic groups.
    1   2   3   4
    Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree
18. I feel a strong attachment towards my own ethnic group.
   1 2 3 4
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

19. I enjoy being around people from ethnic groups other than my own.
   1 2 3 4
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

20. I feel good about my cultural or ethnic background.
   1 2 3 4
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

Write in the number that gives the best answer to each question.

21. My ethnicity is ________________
   1. Black or African American
   2. Biracial; parents are from two different groups
   3. Other (write in):__________________________

22. My father’s ethnicity is (use numbers above)_____________________

23. My mother’s ethnicity is (use numbers above)_____________________

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APPENDIX G
THE BODY ESTEEM SCALE (BES)
Note: Items 36-42 represent the additional recommended ethnic-specific items.

**INSTRUCTIONS:** Please rate how you feel about yourself on the following characteristics:

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9. **energy level**

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10. **thighs**

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11. **ears**

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12. **biceps**

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13. **chin**

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14. **body build**

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15. **physical coordination**

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16. **buttocks**

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17. **agility**

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<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>37. hair texture</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>38. color/shade of skin</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>39. hair length</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>40. hair thickness</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>41. skin texture</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
<tr>
<td>42. hair color</td>
<td>Strongly</td>
<td>Slightly</td>
<td>Neutral</td>
<td>Slightly</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Like</td>
<td>Like</td>
<td>Neutral</td>
<td>Dislike</td>
<td>Dislike</td>
</tr>
</tbody>
</table>
APPENDIX H

THE BULIMIA TEST-REVISED (BULIT-R)
& BODY MASS INDEX (BMI)
Note: Items 6, 11, 19, 20, 27, 29, 31, and 36 are fillers and are not included in the total score.

**INSTRUCTIONS:** Please answer each question by indicating the response that best fits your experience. Please respond to each item as honestly as possible; remember all of the information you provide will be kept strictly confidential.

1. **I am satisfied with my eating patterns.**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>Neutral</td>
<td>Diagree a Little</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
</tbody>
</table>

2. **Would you presently call yourself a “binge eater”?**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, absolutely</td>
<td>Yes</td>
<td>Yes, probably</td>
<td>Yes, possibly</td>
<td>No, probably not</td>
</tr>
</tbody>
</table>

3. **Do you feel you have control over the amount of food you consume?**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most or all the time</td>
<td>A lot of the time</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Never</td>
</tr>
</tbody>
</table>

4. **I am satisfied with the shape and size of my body.**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently or always</td>
<td>Sometimes</td>
<td>Occasionally</td>
<td>Rarely</td>
<td>Seldom or never</td>
</tr>
</tbody>
</table>

5. **When I feel that my eating behavior is out of control, I try to take rather extreme measures to get back on course (strict dieting, fasting, laxatives, diuretics, self-induced vomiting, or vigorous exercise).**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Never or my eating behavior is never out of control</td>
</tr>
</tbody>
</table>

6. **I use laxatives or suppositories to help control my weight**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a day or more</td>
<td>3-6 times a week</td>
<td>Once or twice a week</td>
<td>2-3 times a month</td>
<td>Once a month or less (or never)</td>
</tr>
</tbody>
</table>

7. **I am obsessed about the size and shape of my body.**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or never</td>
</tr>
</tbody>
</table>

8. **There are times when I rapidly eat a very large amount of food.**
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than twice a week</td>
<td>Twice a week</td>
<td>Once a week</td>
<td>2-3 times a month</td>
<td>Once a month or less (or never)</td>
</tr>
</tbody>
</table>
9. How long have you been binge eating (eating uncontrollably to the point of stuffing yourself)?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable; I don’t binge eat</td>
<td>Less than 3 months</td>
<td>3 months to 1 year</td>
<td>1-3 years</td>
<td>3 or more years</td>
</tr>
</tbody>
</table>

10. Most people I know would be amazed if they knew how much food I can consume at one sitting.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without a Doubt</td>
<td>Very probably</td>
<td>Probably</td>
<td>Possibly</td>
<td>No</td>
</tr>
</tbody>
</table>

11. I exercise in order to burn calories.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 2 hours per day</td>
<td>About 2 hours per day</td>
<td>More than 1 but less than 2 hrs/day</td>
<td>One hour or less/day</td>
<td>I exercise but not to burn calories or I don’t exercise</td>
</tr>
</tbody>
</table>

12. Compared with women your age, how preoccupied are you about your weight and body shape?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A great deal more than average</td>
<td>Much more than average</td>
<td>More than average</td>
<td>A little more than average</td>
<td>Average or less than average</td>
</tr>
</tbody>
</table>

13. I am afraid to eat anything for fear that I won’t be able to stop.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or Never</td>
</tr>
</tbody>
</table>

14. I feel tormented by the idea that I am fat or might gain weight.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or Never</td>
</tr>
</tbody>
</table>

15. How often do you intentionally vomit after eating?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or more times per week</td>
<td>Once a week</td>
<td>2-3 times a month</td>
<td>Once a month</td>
<td>Less than once a month or never</td>
</tr>
</tbody>
</table>

16. I eat a lot of food when I’m not even hungry.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very frequently</td>
<td>Frequently</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Seldom or Never</td>
</tr>
</tbody>
</table>

17. My eating patterns are different from the eating patterns of most people.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or Never</td>
</tr>
</tbody>
</table>
18. After I binge eat I turn to one of several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never or Rarely</td>
<td>Occasionally</td>
<td>A lot of the time</td>
<td>Most of all the time</td>
<td></td>
</tr>
<tr>
<td>I don’t binge eat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. I have tried to lose weight by fasting or going on strict diets.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not in the past year</td>
<td>Once in the past year</td>
<td>2-3 times in the past year</td>
<td>4-5 times in the past year</td>
<td>More than 5 times in the past year</td>
</tr>
</tbody>
</table>

20. I exercise vigorously for long periods of time in order to burn calories.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average or less than average</td>
<td>A little more than average</td>
<td>More than average</td>
<td>Much more than average</td>
<td>A great deal more than average</td>
</tr>
</tbody>
</table>

21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets & starches).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or I don’t binge</td>
</tr>
</tbody>
</table>

22. Compared to most people, my ability to control my eating behavior seems to be:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than others’ ability</td>
<td>About the same</td>
<td>Less</td>
<td>Much less</td>
<td>I have absolutely no control</td>
</tr>
</tbody>
</table>

23. I would presently label myself a “compulsive eater” (one who engages in episodes of uncontrolled eating).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, absolutely</td>
<td>Yes</td>
<td>Yes, probably</td>
<td>Yes, possibly</td>
<td>No, probably not</td>
</tr>
</tbody>
</table>

24. I hate the way my body looks after I eat too much.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seldom or Never</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Almost always</td>
<td>Always</td>
</tr>
</tbody>
</table>

25. When I am trying to keep from gaining weight, I feel that I have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>A lot of the time</td>
<td>Most or all of the time</td>
</tr>
</tbody>
</table>

26. Do you believe that it is easier for you to vomit than it is for most people?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, it’s no problem at all for me</td>
<td>Yes, it’s easier</td>
<td>Yes, it’s a little easier</td>
<td>About the same</td>
<td>No, it’s less easy</td>
</tr>
</tbody>
</table>
27. I use diuretics (water pills) to help control my weight.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Very frequently</td>
</tr>
</tbody>
</table>

28. I feel that food controls my life.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Almost always</td>
<td>Frequently</td>
<td>Sometimes</td>
<td>Seldom or Never</td>
</tr>
</tbody>
</table>

29. I try to control my weight by eating little or no food for a day or longer.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Very frequently</td>
</tr>
</tbody>
</table>

30. When consuming a large quantity of food, at what rate of speed do you usually eat?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>More rapidly than most people have ever eaten in their lives</td>
<td>A lot more rapidly than most people</td>
<td>A little more rapidly than most people</td>
<td>About the same rate as most people</td>
<td>More slowly than most people (or not applicable)</td>
</tr>
</tbody>
</table>

31. I use laxatives or suppositories to help control my weight.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Very frequently</td>
</tr>
</tbody>
</table>

32. Right after I binge eat I feel:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>So fat and bloated I can’t stand it</td>
<td>Extremely fat</td>
<td>Fat</td>
<td>A little fat</td>
<td>OK about how my body looks or I don’t binge eat</td>
</tr>
</tbody>
</table>

33. Compared to other people of my sex, my ability to always feel in control of how much I eat is:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>About the same or greater</td>
<td>A little less</td>
<td>Less</td>
<td>Much less</td>
<td>A great deal less</td>
</tr>
</tbody>
</table>

34. In the last 3 months, on the average how often did you binge eat (eat uncontrollably to the point of stuffing yourself)?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a month</td>
<td>2-3 times a month</td>
<td>Once a week</td>
<td>Twice a week</td>
<td>More than twice a week</td>
</tr>
</tbody>
</table>

35. Most people I know would be surprised at how fat I look after I eat a lot of food.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>Yes</td>
<td>Yes, probably</td>
<td>Yes, possibly</td>
<td>No, probably not or I never eat a lot of food</td>
</tr>
</tbody>
</table>
36. I use diuretics (water pills) to help control my weight.

<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></td>
<td>3 times a week</td>
<td>Once or twice a week</td>
<td>2-3 times a month</td>
<td>Once a month</td>
<td>Never</td>
</tr>
</tbody>
</table>

Please enter your height _______
Please enter your weight _______
APPENDIX I

E-MAIL SOLICITATION SENT TO PARTICIPANTS
Hello!

My name is Jennifer Wilcox, and I am a graduate student in the Counseling Psychology Ph.D. Program in the Department of Psychology at The Ohio State University. Along with my advisor, Tracy Tylka, I am conducting a research study exploring African American women's experiences within culture, experiences with discrimination, sense of self as an African American woman, eating habits and beliefs about appearance. The only requirement for participation is that you identify as an African American woman and you are 18 years of age or older.

The general purpose of this study is to better understand how African American women embrace health and wellness. By participating and sharing your experiences, you will be contributing invaluable information that will lead to better understanding and promotion of health and wellness in the African American community.

If you choose to participate in this study, please click on the link below. The survey will take approximately 30-40 minutes to complete. If you choose to participate, you will have the option to enter a lottery drawing in which one to three individuals will be selected to win $50. The only requirement for entering this lottery is that you complete the survey and provide your e-mail address. After completing the survey, you will be asked to enter your e-mail address if you would like to participate in the lottery drawing. You are only required to provide this information if you choose to enter the drawing.

Due to the nature of Internet research, the security of the survey data during transmission cannot be guaranteed; however, no identifying information is required. Security is guaranteed once the researchers receive the data. Your responses will be kept strictly confidential. If you would like further information about this study, please do not hesitate to contact me at wilcox.64@osu.edu. You may also contact my advisor Dr. Tracy Tylka at tylka.2@osu.edu.

The methods of this research and the plan for protection of rights of participants have been reviewed and approved by the Office of Responsible Research Practices (http://www.orrp.ohio-state.edu/), which oversees all research activities conducted at The Ohio State University. This plan received Institutional Review Board approval on August 15, 2005.

Please feel free to forward this email and link to other African American women who may be interested in participating.

If you have read this email and would like to take the survey, please click on the URL below:

http://www.surveymonkey.com/s.asp?u=34557741922 (this is a sample link. Actual link will be entered once survey is up and running).

Thank you very much for your time and participation!

Sincerely,
Jennifer A. Wilcox, M. A.
Doctoral Candidate
Department of Psychology, The Ohio State University
APPENDIX J

SCRIPT – FIRST PAGE OF STUDY
SURVEY OF AFRICAN AMERICAN WOMEN

African American Women Only!

These questionnaires ask you question about your experiences within culture, experiences with discrimination, personal identity characteristics, eating habits, beliefs about appearance, your body perceptions and your sense of yourself as an African American woman.

Although the confidentiality of on-line responses cannot be guaranteed, additional security measures have been taken to protect the confidentiality of your responses (e.g., encryption of data during transmission) and no identifying information is required. Furthermore, we guarantee that your responses will be kept strictly confidential once the researchers receive the data—so-

***Please answer all items in the survey.

***Please answer all items honestly

By completing this survey honestly you will be contributing to much needed knowledge about the concerns and strengths of the African American community. This information will help provide services that are relevant to this community of women.

Thank you for your participation!
APPENDIX K

CONSENT FOR PARTICIPATION
The Ohio State University Consent to Participation in Research

<table>
<thead>
<tr>
<th>Protocol title:</th>
<th>Survey of African American College Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol number:</td>
<td>2005B0228</td>
</tr>
<tr>
<td>Principal Investigator:</td>
<td>Dr. Tracy Tylka</td>
</tr>
</tbody>
</table>

I consent to my participation in research being conducted by Jennifer Wilcox and Tracy Tylka of The Ohio State University.

The investigators have explained the purpose of the study, the procedures that will be followed, and the amount of time it will take. The researchers have also explained the possible risks (e.g., confidentiality cannot be guaranteed on-line) and benefits (e.g., valuable information regarding health/wellness of African American women) of my participation.

I have had a chance to ask questions and to obtain answers to my questions. I can contact the investigators at wilcox.64@osu.edu; tylka.2@osu.edu at any point with questions/concerns.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Furthermore, I understand that I am free to withdraw consent at any time and to discontinue participation in the study without prejudice to me.

Finally, I acknowledge that I have read and fully understand the consent form.

For questions about my rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, I may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

If you agree with the above please indicate your agreement by typing yes to continue with the study.
APPENDIX L

DEBRIEFING STATEMENT
Thank you for participating in this study! You have completed a study composed of several questionnaires which assess your experiences with discrimination, your feelings about your personal identities, your feelings about appearance/self/body, and your eating habits.

The primary purpose of this study is to expand and enhance the existing research findings regarding African American women’s experiences with racism, sexism, body image, eating habits and identity development. The results of this research will hopefully lead to a better understanding of how African American women cope with experiences of discrimination in healthy ways and how such experiences interact with identity development, body image, and eating patterns.

Because the questionnaires are personal in nature and deal with sensitive topics, it is possible that you may have developed some concerns during the course of this study. If this is the case, please feel free to contact the researchers (wilcox.64@osu.edu, tylka.2@osu.edu) or a local counseling center. For OSU students, The Psychological Services Center (141 Townshend Hall; 292-2059), a training facility for doctoral psychology students, provides free counseling services to Ohio State students. In addition, Counseling and Consultation Services (4th floor of the Younkin Success Center; 292-5766), provides psychological services to students at the university. For non-OSU students, you may also contact your university’s counseling center or the researchers with questions/concerns.

If you have any further questions about this study, please do not hesitate to contact the researchers.

Again, thank you for assisting with this research. Your participation is greatly appreciated.

Sincerely,
Jennifer A. Wilcox, M.A. (wilcox.64@osu.edu)
Tracy Tylka, Ph.D. (tylka.2@osu.edu)
LIST OF REFERENCES


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Vandiver, B.J. (2002). What do we know and where do we go from here? The Counseling Psychologist, 30, 96-104.


