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The influence of womanist identity on the development of eating disorders and depression in African American female college students

Theresa Ford
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**THE INFLUENCE OF WOMANIST IDENTITY ON THE DEVELOPMENT OF
EATING DISORDERS AND DEPRESSION IN AFRICAN AMERICAN
FEMALE COLLEGE STUDENTS**

A Dissertation

Presented to

The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

by

Theresa Ford

May 2000

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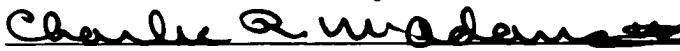
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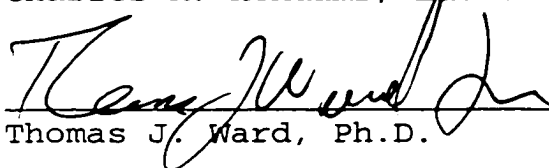
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Dedication

This work is dedicated to Sharan, who would have been
proud.

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**The Influence of Womanist Identity on the Development of
Eating Disorders and Depression in African American
Female College Students**

Abstract

The purpose of this study was to investigate the relationships among eating disorders, depression, and womanist identity in African American college women. An African American feminist perspective was employed to consider these disorders within a larger context.

Seventy African American undergraduate women were recruited from one predominantly white and one predominantly African American university in central Virginia. Participants were administered the Beck Depression Inventory, Eating Disorder Inventory, Binge Scale, and Womanist Identity Attitudes Scale.

It was hypothesized that African American college women would have eating disorders in the same proportion as white college women, that binge eating disorder would be the most common eating disorder in study participants, that there would be a positive relationship between the level of depression and the existence of eating disorders, and a relationship existed between womanist identity and eating disorders and/or depression.

Full-fledged eating disorders were not discovered among this sample, although there was evidence of problematic eating patterns in some participants, particularly at the predominantly white university. In addition, women at the predominantly white university had significantly higher depression scores. Depressive symptoms and eating problems were strongly correlated. The lack of variation in the scores on the female identity measure made it impossible to determine the relationship of womanist identity to the disorders. Further study is needed to understand eating problems and depression in the African American college population.

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**THE INFLUENCE OF WOMANIST IDENTITY ON THE DEVELOPMENT OF
EATING DISORDERS AND DEPRESSION IN AFRICAN AMERICAN
FEMALE COLLEGE STUDENTS**

CHAPTER 1

INTRODUCTION

Statement of the Problem

Little research has been done on the lives of African American women which examines their unique history, challenges, needs, strengths, coping strategies, or the most appropriate clinical interventions in working with them. African American women have been the target of a great deal of myths and misinformation.

The present study attempted to rectify the paucity of accurate information by investigating the twin phenomena of eating disorders and depression in African American college women. This study also explored whether a strong identity as a woman offers some protection from eating disorders and depression by mediating the effects of racism, sexism, and economic inequality.

The perspective of feminist theory was employed, and consideration given to the impact of racism, sexism, and socioeconomic class in the lives of women, as well as the potential for these forces to impede women's personal growth and empowerment. These issues were also examined within a cultural context, taking into consideration the history, culture, and lived experiences of African American women. To that end, the work of African American feminists was highlighted.

Two seemingly conflicting perspectives regarding

African American women exist: One states they are triply disadvantaged due to race, gender, and economic status (Gibbs & Fuery, 1998; Smith, 1981). In fact, the pervasiveness and intractability of poverty is a continuing source of stress in the lives of many African American women (Wenk & Hardesty, 1993). As a consequence, many women experience inadequate housing, inferior schooling for their children, inaccessible or substandard health care, and limited mobility (Gibbs & Fuery, 1998).

African American women are more likely to be the victims of sexual and physical violence, robbery, and a host of serious crimes. They also have more chronic health problems, higher mortality rates, and are more often the sole source of income for the family (Davis, 1997; Gibbs & Fuery, 1998).

In addition, African American women are subjected to a multitude of negative stereotypes, for which there is no corollary in the experience of white women. These pervasive and demeaning stereotypes deny the humanity of African American women and adversely affect how they are viewed by others. In some cases, these false depictions affect how women feel about themselves. Individuals may find themselves acting out or acting against these myths (Greene, 1994). The stereotypes are rooted in slavery and have been used to justify the subjugation and exploitation of African American women. Examples are the

hardworking, selfless, overweight Mammy; the sharp tongued, emasculating Sapphire; the oversexed, manipulative Jezebel; and the lazy, incompetent Welfare Mother (Collins, 1991; hooks, 1984; Mitchell & Herring, 1998; Taylor, 1999; Thompson, 1994a; West, 1995).

The other view of African American women portrays them as strong, resilient, and capable of adapting to any number of situations in order to meet their own needs, support their families, and communities (Collins, 1991; Gibbs & Fuery, 1998). This contention is supported by employment data on African American women.

Although African American women lag behind African American men in wages, and are much more frequently concentrated in lower paying jobs than white women, African American women have a higher level of education and a higher proportion are employed in professional and white collar positions than African American men. Professional African American women have even reached income parity with white women (Gibbs & Fuery, 1998). In addition, researchers have noted positive self-concept equal to or higher than African American males or white females, that African American women are less bound to strict gender roles, and often enjoy egalitarian relationships with their partners (Greene, 1994; Gibbs & Fuery, 1998). "In response to segregation and discrimination, Black women have developed a set of implicit attitudes and explicit behaviors which enable

them to identify internal sources of self-esteem...to surmount barriers to their aspirations and goals, to support families with meager resources" (Giddings, 1984; McAdoo, 1981, cited in Gibbs & Fuery, 1998, p. 372).

Rather than choosing one perspective over another, it is quite possible to accept both as true; African American women experience an inordinate amount of stress and adversity but are still an amazingly resourceful group of individuals who prevail and often excel despite the odds.

It is reasonable to assume however, that when any individual or group is subjected to extreme stress over long periods of time, there are possible consequences. It has been documented that a relationship exists between stressful life events and the development of mental health disorders or other problematic behaviors (Gibbs & Fuery, 1998; Striegel-Moore & Smolak, 1996).

Need for the Study

More information is needed on how mental health issues affect African American women. Clinical work with African Americans has been largely based on practices and constructs developed with white clients. African American culture, if considered at all, is often viewed as a variation of white culture (Jackson, 1992).

The development of eating disorders and depression, either singly or in combination, is a possible outcome of

the enormous stress that African American women face on a daily basis (Barbee, 1992; McGrath, Keita, Strickland, & Russo, 1990; Mitchell & Herring, 1998; Striegel-Moore & Smolak, 1996; Thompson, 1992, 1994a, 1994b). In addition, there appears to be a relationship between the two disorders (Grubb, Sellars, & Waligroski, 1993; McGrath et al., 1990; Willcox & Sattler, 1996).

Eating Disorders and African American Women

Eating disorders occur mostly in women (American Psychiatric Association, 1994; Harris & Kuba, 1997; Root, 1990; Smolak & Levine, 1994) and the prevalence is growing (Orbach, 1988; Willcox & Sattler, 1996). Many theorists believe that pressure to be thin and attractive, which in Western society are often considered synonymous, propels much of the disordered eating behavior among women (Laidlaw, 1990; Orbach, 1988).

Until recently the prevailing notion was that eating disorders were rare in African American women (Hsu, 1987; Powell & Kahn, 1995; Root, 1990; Strigel-Moore & Smolak, 1996; Thompson, 1992; 1994a). Much of this conclusion was based on studies that found African American women, although heavier on the average, were more satisfied with their bodies than white women, had larger ideal body sizes, and felt less pressure to be thin than their white counterparts (Hsu, 1987; Molloy & Herzberger, 1998; Powell & Kahn, 1995; Stevens, Kumanyika, & Keil, 1994). It was even found that African American women's regard

for their bodies was less affected by the negative opinion of others (Henriques, Calhoun, & Cann, 1996).

However, these myths concerning eating disorders and African American women have been convincingly disputed. Many researchers have discovered ample evidence of the existence of disordered eating patterns in African American women and found that acceptance of larger bodies doesn't preclude the existence of eating problems (Harris & Kuba, 1997; Hsu, 1987; Pinkowish, 1995; Rand & Kuldau, 1990; Striegel-Moore & Smolak, 1996; Thompson, 1992, 1994a, 1994b).

In one of the largest studies of African American women's eating behaviors and attitudes, *Essence* magazine surveyed 2000 individuals and found that African American women suffer from eating disorders in at least the same proportion as white women. Over 70% of the respondents reported being preoccupied with a desire to be thinner and the same percentage stated they were terrified of being overweight (Villarosa, 1994).

The assumption of a monolithic African American community with one set of values and standards is false as well as misleading. Issues of class are inescapable in discussing African Americans and standards may vary for different communities. As African American women move up the socioeconomic ladder, away from traditional working-class and lower-middle-class communities and have more interaction with whites, they are more vulnerable to

the beauty standards of the larger society which values thinness, and may be more prone to eating problems (Henriques et al., 1996; Hsu, 1987; Thompson, 1994a; Villarosa, 1994). It should be noted that the participants in the Essence survey were substantially more educated and had higher incomes than most African American women.

Root (1990) suggests that culture may offer protection to African American women as a group, but does not necessarily insulate the individual from the values of the dominant culture, especially if the individual's culture is devalued by the dominant group. Root also contends that women of color are of necessity bicultural, which makes them more vulnerable to the standards of the larger society.

In addition, many African American women who are satisfied with their weight may feel burdened with white standards of beauty relating to skin color, hair texture, and facial features. They may also feel constricted by demeaning stereotypes imposed by the larger society which suggest that they are less valuable or have more negative attributes than other women (Mitchell & Herring, 1998; Taylor, 1999; Thompson, 1994a; West, 1995).

The DSM-IV recognizes anorexia and bulimia as eating disorders, yet there is growing evidence of an additional disorder, referred to as compulsive overeating or binge eating disorder (BED). This disorder entails regularly

consuming huge amounts of food without purging or other compensatory activities. There is also an absence of control over food and significant distress about eating behavior (APA, 1994). Dieting or a desire to be thin may not be present. As a consequence, binge eaters are often overweight. (Devlin, Walsh, & Spitzer, 1992; Harris & Kuba, 1997; Walsh, 1997). Walsh (1997) estimates that this disorder affects two to five percent of the population and is more common than anorexia, which affects less than one percent, or bulimia, which affects one to three percent of Americans.

One theory on the etiology of binge eating disorder is that obesity predisposes an individual toward or results from binge eating (Fitzgibbon et al., 1998). Another theory suggests that BED is closely linked to mood disorders such as depression (Fitzgibbon et al., 1998; Grissett & Fitzgibbon, 1996; Marcus et al., 1990). A third theory states that relaxed attitudes about food, dieting, and body image may ultimately result in obesity and/or BED (Fitzgibbon et al., 1998; Rucker & Cash, 1992). A final theory holds that BED is related to stress and oppression; individuals who engage in binge eating, do so in an effort to manage uncomfortable feelings, self-soothe, and attempt to exercise control over situations which are beyond their control (Thompson, 1992, 1994a).

The American Psychiatric Association currently lists binge eating disorder under the category, "Eating Disorders Not Otherwise Specified" and offers research criteria (APA, 1994). There is no corresponding code in the DSM-IV for BED and it is not typically assessed in eating disorder inventories.

The lack of recognition of BED is of great concern because it is the primary eating problem affecting African American women (Crute, 1997; Harris & Kuba, 1997; Pinkowish, 1995). A National Institute of Health study reported that four percent of African American women surveyed were binge eaters, one percent were bulimic and less than one percent were anorexic. It has also been suggested that although BED is most common, anorexia and bulimia are on the rise (Crute, 1997).

Rand and Kuldau (1990) found that African American women were more likely to be obese as compared to white women, white men, or African American men, even when the effects of socioeconomic status were controlled. These findings on binge eating and weight may help explain the large numbers of African American women who are overweight.

As new information comes to light regarding eating disorders and African American women, more research is needed. It is imperative that these issues be explored to answer questions on the numbers of African American women affected by eating disorders, whether African

American women are more or less prone to specific disorders, and the role that culture plays in prohibiting or promoting eating problems. We also need to know much more about the role of external stressors in the development of eating disorders.

Depression and African American Women

Another myth regarding African American women is that they possess superhuman strength that prevents them from experiencing depression. This stereotype, while perpetuated by white society, has unfortunately been accepted by many African Americans so that women's legitimate need for counseling and other services is questioned by some; similarly, the very right of African American women to be unhappy or distressed is challenged (Danquah, 1998; Greene, 1994; Mitchell & Herring, 1998). The dehumanizing effects of the aforementioned stereotypes make it difficult for some individuals, even professionals, to consider African American women's mental health needs.

Possible causes for depression in women overall include physiological and/or psychological predisposition, and experiences such as sexual or physical abuse, poverty, lack of support, low self-esteem, and less perceived life control (McGrath et al., 1990; Mitchell & Herring, 1998). It has also been found that chronic stress, rather than acute life events, contributes to women's depression (Sprock & Yoder, 1997).

Research on depression in African American women yields conflicting results. The American Psychological Association's National Task Force on Women and Depression (McGrath et al., 1990) reviewed the findings of hundreds of research studies and concluded that depression was the most common psychological problem for all women, regardless of ethnicity. They also found that women of color were more likely to experience a number of economic risk factors for depression, including discrimination, lower educational and income levels, low status and high stress jobs, unemployment, poor health, larger family sizes, marital discord, and single parenthood. In addition, they asserted that gender and racial bias on the part of clinicians negatively affected diagnosis and treatment.

A study by Reed, McLeod, Randall, & Walker (1996) found that 58% of the African American female college students sampled experienced some form of depressive symptoms. McGrath et al. (1990) cited a 1983 study by Russo and Olmedo which determined that African American women had a 42% higher rate of depression than white women. Barbee (1992) concurred that depression is a wide spread problem among African American women and asserted that mental illness exists in a sociopolitical context. Acontextual research on depression in African American women is criticized:

Acontextual depression research ignores the

interactive effects of gender, race, and at times, social class in the oppression of African American women. It is not enough to just speak of risk factors. Nor does asking how often one feels sad assist in the understanding of African American women and depression. To explore the context of African American women's depression, questions need to be aimed at what causes them to feel the way they do, why they feel the way they do, and what they need to assist them in feeling better (Barbee, 1992, p. 259).

In contrast, the Substance Abuse and Mental Health Statistics Sourcebook (Rouse, 1995) suggested that African American women experience depression less often than white women. They reported a lifetime prevalence rate for depression of 21.3% for white women and 15.5% for African American women. Due to the many gaps in our knowledge and these contradictory findings, further investigation on this topic is warranted.

Regarding the etiology of depression in African American women, Mitchell & Herring (1998) state, "no one knows if the causes of depression are different for Black women. Until recently, few people thought to ask. We simply weren't important enough...Common sense tell us that living in a society that places little value on our Blackness or our femaleness must take its toll on our psyches as well as our bodies." (p. 146-147).

Since African American women have a unique history, particular strengths, and often a heightened set of stressors which distinguish them from white women and even other women of color, it may not be farfetched that mental illnesses such as depression are expressed in ways that are different from other populations of women. Research is needed in order to answer questions regarding the number of African American women who suffer from depression, its causes, presentation, and appropriate treatments for this illness.

Eating Disorders and Depression Among College Women

It is well known that eating disorders are rampant among white college women (Fredenberg, Berglund, & Dieken, 1996; Minz & Betz, 1988; Schwitzer, Bergholz, Dore, & Salimi, 1998), yet little work has been done on African American college women. Are African American college women more or less prone to eating disorders? Are their patterns different or similar to African American women in the general population? What are the particular stressors that contribute to eating problems among African American female college students? That these questions have not been answered indicates a serious gap in the literature.

In addition, information exists regarding the serious nature of depression in white female adolescents and college age women (McGrath et al., 1990; Sands, 1998;

Sprock & Yoder, 1997) but less is known about depression in African American females in that same age group. Herein lies another critical gap in the literature.

The Role of Protective Factors

Since eating disorders and depression are serious problems, it is important to consider protective factors that mitigate the effects of external stressors and lessen the individual's vulnerability to these disorders. One's identity as a women, referred to by some African American women as womanist identity (Walker, 1983), was considered in this study. A strong womanist identity in African American females is positively correlated with high self-esteem and mental health (Ossana, Helms, & Leonard, 1992; Parks, Carter, & Gushue, 1996). Womanist identity, however, has not been considered in relation to eating disorders and depression.

Justification for Proposed Study

Although more recent studies acknowledge the existence of eating disorders and the problem of depression in African American women, there is not a comprehensive body of literature on either phenomenon with regards to women of color, nor is there research specifically relating to African American women connecting the two disorders. Much of what is written is filled with false assumptions and misperceptions. Additionally, little that is written is contextual.

Surprisingly few research studies have been devoted to African American college women, and no evidence has been found in the literature of studies exploring the relationship of womanist identity to eating disorders and depression in African American female college students.

Theoretical Rationale

Feminist writers relate problems experienced by women, such as eating disorders and depression, to their powerlessness. Women have access to and control over food in a way that they do not have access to power and control over other areas of their lives. Similarly, the development of depressive symptoms is viewed as a logical response to trauma and extremely stressful life conditions. This conceptualization removes the stigma of pathology from the individual and invites examination of the external factors influencing distress and maladaptive behaviors (Laidlaw, 1990; Smith & Siegel, 1985; Thompson, 1992, 1994a, 1994b).

It is interesting to note that the American Psychological Association's Task Force on Women and Depression (McGrath et al., 1990) advocated utilizing feminist theory in understanding and treating problems such as depression in women, including women of color. They found such a perspective helpful in providing context and understanding the external forces that contribute to this disorder.

Feminists of color argue persuasively that although some white feminists have been guilty of racism and classism in the exclusiveness of their definitions and their assumptions regarding possible beneficiaries of feminism, the feminist perspective, with its emphasis on power relationships, has much to offer women of color (Collins, 1991; Espin, 1994; hooks, 1981, 1984). Even so, due to the life circumstances under which women of color live, some adaptations must be made. The oppression of African American women takes on added dimensions due to issues of race and gender. "The characteristics are molded by forces that multiply and reinforce each other, as well as by the particular situation of men of color in this society" (Espin, 1994, p. 265).

With regards to men of color, manhood in the larger society is defined by power and achievement in the form of career status and monetary rewards. This is unattainable for many men of color. Thus, the expression of manhood may become distorted, and asserting dominance over women and children may be one of the few ways that a poor or working class man can achieve some degree of control in his life. Those closest to him may be the target of his rage. In addition, African American men are saddled with their own brand of pernicious stereotypes. According to these myths, the African American man's chief distinguishing features are his

sexual prowess and propensity for violence. African American women who empathize with the plight of their men may accept ill treatment and subordinate their own needs in deference to men (Espin, 1994). This situation can compound the woman's stressors and deny her the benefits that a supportive relationship with a mate can offer.

An entire body of feminist literature exists which examines the intersection of gender, race, and class. Black feminist thought draws upon the unique history and experiences of African American women and combines their particular brand of intellectual thought with activism (Collins, 1991; Davis, 1981; hooks, 1981, 1984; Smith, 1995; Taylor, 1998). These writings were explored extensively.

The present study adds to the literature by investigating eating disorders and depression in a specific population of African American women. It also offers suggestions for additional research, and underscores the need for appropriate treatments and the establishment of protocols for prevention and early intervention.

This study significantly adds to the body of feminist literature by exploring influences affecting the development of eating disorders and depression in African American college women and whether womanist identity can mitigate the effects. Since traditional feminist theory does not always specifically address the issues of

African American women (Collins, 1991; hooks, 1984; Taylor, 1998) this study represents an important expansion.

Definition of Terms

African American: This term connotes women of African descent, individuals whose ancestors were originally from sub-Saharan African, but the individuals were born in the United States.

Black Feminist Thought: Collins (1991) describes this concept as, "the tension between the suppression of Black women's ideas and our intellectual activism in the face of that suppression" (p. 5-6). This conceptualization entails African American women defining themselves, actively challenging racism, sexism, and class privilege, and drawing upon their history and cultural heritage.

Depression: DSM-IV categories of unipolar depression include major depression and dysthymia. Major depression entails at least 2 weeks of symptoms such as extreme sadness, loss of interest in activities, weight loss or gain, sleep disturbances, loss of energy, difficulties in thinking or movement, negative self-evaluation, and thoughts of death. Dysthymia occurs over a minimum of 2 years and includes eating or sleep disturbances, lack of energy, low self-esteem, difficulties in concentrating, or feelings of hopelessness (APA, 1994). Participants in this study were administered the Beck Depression Inventory, and the resultant scores were used to diagnose

whether study participants were depressed, and if so, to what extent.

Eating Disorders: The DSM-IV (APA, 1994) reports that eating disorders are characterized by extreme disturbances in eating behavior. The specific disorders are as follows:

Anorexia Nervosa is a condition whereby an individual refuses to eat or maintain a minimally normal weight and is preoccupied with body size.

Binge Eating Disorder (BED) is defined as regularly consuming large amounts of food in the absence of purging or other compensatory activities. It is currently listed under the category "Eating Disorders Not Otherwise Specified."

Bulimia entails regularly overeating and purging or engaging in other compensatory activities such as dieting and exercise.

Feminist Theory: This theory is derived from a set of beliefs and activities designed to end discrimination and exploitation based on sex, race, or class. It does not privilege women over men or solely advocate the goals of one group, but is potentially beneficial to all people (hooks, 1984).

Womanist Identity: Womanist identity refers to beliefs and attitudes regarding gender. Participants were assessed with respect to their feelings about women.

Many gaps in the literature were highlighted. This study attempted to close some of those gaps by asking pertinent questions regarding African American college women and exploring issues that had not previously been examined.

Research Questions and Hypotheses

Questions

The following questions were considered in this study:

1. Do African American female college students have eating disorders in the same proportion as white female college students?
2. Is binge eating disorder the most common eating disorder in African American female college students?
3. What is the relationship between eating disorders and depression in African American college women?
4. Is there a relationship between womanist identity and the development of eating disorders or depression in African American female college students?

Hypotheses

The following hypotheses were advanced in this study:

1. African American female college students will have eating disorders in the same proportion as white female college students.

2. Binge eating disorder will be the most common disorder in African American female college students.
3. There is a positive relationship between the level of depression and the existence of eating disorders in African American female college students.
4. There is a relationship between womanist identity and the development of eating disorders and depression in African American female college students.

Methodology

The population was African American college women in The US. Participants were African American female undergraduate volunteers attending one predominantly white and one predominantly African American university in central Virginia.

A mixed design was planned, with both a quantitative and qualitative component. Correlational methods, chi square analysis, and discriminant analysis were planned in the quantitative portion in order to ascertain the relationship between eating disorders and depression, compare the proportion of African American college women with eating disorders to white college women, and relate independent variables to membership in one of four groups indicating specific disorders or no symptomatology. However, participant scores on one of the instruments

negated the possibility of performing a discriminant analysis.

In addition, there were plans for a qualitative component in which a few women would be interviewed. Regrettably, participant cooperation was lacking in the qualitative component.

CHAPTER 2

REVIEW OF THE LITERATURE

In the previous chapter it was established that African American women face a variety of challenges. The assumption that African American women are immune to eating problems has been refuted by recent studies that revealed problematic eating patterns, most notably binge eating disorder. Less is known, however, about the eating patterns of African American college women.

African American women are also subject to a number of risk factors that make them vulnerable to depression. Little conclusive information exists regarding the rates of depression in African American women but the research indicates that this disorder is a serious problem. Again, there is little information on prevalence rates in the college population.

There are physiological and psychological predisposing factors to these disorders, as well as cultural influences, but the enormous stress that African American women face due to racial, gender, and economic discrimination, plays a significant role. These issues are viewed through the lens of feminist theory, particularly the work of African American feminists, due to their emphasis on power relationships and the importance accorded to race, gender, and economic status.

Finally, womanist identity is raised as a possible

protective factor against the development of these disorders. Womanist identity is positively correlated with mental health, but has not been considered in relation to eating problems and depression.

This chapter examines the theoretical underpinnings of feminism and current research on eating disorders and depression in African American women, focuses specifically on African American college students, and also considers womanist identity. The connections between these issues are emphasized.

Theoretical Foundations

Feminism/Black Feminist Thought

The tenets of feminism broadly state that women are disadvantaged due to gender and are subject to exploitation on a number of levels, including economically and sexually. Women are also vulnerable to being narrowly and negatively defined, not only by men, but by an entire system which reinforces patriarchal relationships. The notion of the "personal as political," encouraging women to view their individual circumstances in a larger political context is also fundamental to feminist theory. Empowering women politically, economically, and socially are generally seen as viable and necessary goals (Laidlaw, 1990; Rosewater & Walker, 1985; Smith & Siegel, 1985).

While finding many of the concepts valuable, some feminists, particularly women of color, find the history

and many aspects feminism as it was originally and is currently espoused, quite troubling. These concerns eventually led African American women to develop a set of feminist principles and engage in activities which spoke to their realities and needs.

During the late 1800s and early 1900s privileged white women advocated for their right to vote, ignoring the needs of poor and African American women. Although African American women participated in the suffrage movement, their participation was devalued and sometimes discouraged by white suffragists. When white women won the vote, they considered their battle over (Collins, 1991; Davis, 1981; Taylor, 1998).

In her discussion of the origins of African American feminism, Taylor (1998) points out that African American women advocating for their rights, first rooted in the anti-slavery movement and later connected to the civil rights struggle, actually predates the activism of white feminists. As early as 1831, Maria Stewart exhorted African American women to "Arise! No longer sleep or slumber but distinguish yourselves" (Collins, 1991, p. 92). Some important differences, however, were that the activities of African American feminists were often undertaken by poor women and were not construed as anti-male.

A desire to work and find fulfillment outside the home originally galvanized many white women in the 1970s,

only later did issues of economic disparity surface. This is in stark contrast to the experience of African American women who out of necessity have always been a part of the labor force, initially due to forced servitude and later as low paid wage earners (Collins, 1991; Davis, 1981; hooks, 1981, 1984; King, 1995; Taylor, 1998).

Issues of racial justice were not always a part of the feminist agenda and even now take a back seat to gender concerns (Collins, 1991; Higginbotham, 1992; hooks, 1981, 1984). Thompson (1994b), who is white, criticizes current feminist thought for "privileging sexism over other oppressions... (and) attributing problematic family dynamics to patriarchy while ignoring the role of racism and religious discrimination" (p. 358-359).

African American women who joined with white feminists during the '70s often found their concerns downplayed, differences minimized, and the experience of middle class white women held up as representative of all women. Many African American women withdrew from these organizations, formed their own groups and began to articulate a vision of feminism particular to African American women (hooks, 1981, 1984; King, 1995).

The Combahee River Collective, which was the Boston chapter of the National Black Feminist Organization, was formed in 1974 and issued the now famous "A Black

Feminist Statement." In it they affirmed the value of African American women and the necessity for liberation, not as an adjunct to someone else's freedom, but due to African American women's inherent right to autonomy (Combahee River Collective, 1995).

Smith (1995), one of the founders of the Combahee River Collective and a leading African American feminist, disputes many of the myths perpetrated in and outside of the African American community about the salience of feminism in the lives of African American women. She answers claims that African American women are already free with the argument that being forced to head families, work outside the home and carry a number of responsibilities by themselves out of necessity cannot be equated with freedom. She also argues that no one ever suggested that the experience of poverty, unequal pay, or violence made African American men free.

In addition, Smith (1995) challenges the belief that racism is the only or primary oppression facing African American women. "We examined our own lives and found that everything out there was kicking our behinds, race, class, sex, and homophobia. We saw no reason to rank oppression, or as many forces in the black community would have us do, pretend that sexism...was not happening to us" (p. 260).

Black feminist thought as described by Collins (1991), posits that African American women have a set of

experiences that are different from those who are not African American or female, and addresses the oppression of African American women in three areas: the exploitation of African American women's labor; political disenfranchisement; and the preponderance of negative images of African American women. Black feminist thought interprets the experiences of African American women by the very individuals who live the experience.

King (1995) asserts that an African American feminist ideology "declares the visibility of black women." African American women affirming their existence and importance is particularly significant given their historical treatment in the larger society and even in other liberation movements. The civil rights/Black power movement was controlled by African American men and often concentrated on their needs. And as previously stated, the women's liberation movement focused on the concerns of white women. Self-determination is of paramount importance in African American feminist theory, and despite their oppression, African American women are viewed as powerful beings capable of independent action.

King (1995) also states that the term "triple jeopardy" sometimes used to describe barriers of race, gender, and economic status is inaccurate, and rejects the idea that each discrimination is separate and the relationship additive. Instead she prefers the term

"multiple jeopardies" to connote an interdependent, interactive process which is multiplicative rather than additive. It is the task of African American feminists to develop a political ideology capable of interpreting and resisting these multiple jeopardies.

In addition, hooks (1981, 1984) advocates a more inclusive brand of feminism that seeks to end oppression for all people. This conception of feminism, particular to African American women, but with the potential to benefit many other persons and groups is being utilized as an overarching theory in this study.

Womanist Identity

Alice Walker (1983) popularized the term womanist, which she describes as "A black feminist or feminist of color...Appreciates and prefers women's culture, women's emotional flexibility...and women's strength...Committed to survival and wholeness of entire people, male and female" (p. xi). Helms (Ossana, Helms, & Leonard, 1992) used the term popularized by Walker to denote a positive female identity and developed the Womanist Identity Attitudes Scale (WIAS) to assess a woman's feelings and attitudes regarding gender. The WIAS is based on Cross's (1971) and Helms' (1984) models of racial identity development and employs four stages: The Preencounter stage involves identification with traditional standards of womanhood, devaluation of women and elevation of men. The Encounter stage entails questioning one's previous

values and beliefs. In the Immersion-Emersion stage, the individual elevates woman, rejects men as a reference group, and seeks affiliation with other women. By the time a woman reaches the Internalization stage, she has developed her own positive definition of womanhood and has a better sense of balance, understanding that being pro-woman does not make her anti-male.

Empirical Studies

Womanist Identity Assessment Measures

Prior to the development of the womanist identity model and WIAS (Ossana et al., 1992), other researchers explored women's identity development. Based on the racial identity model, Downing and Roush (1985) developed a feminist identity model. While appearing to measure some of the same constructs as the WIAS, it may be inferred from this instrument that healthy development entails adopting a particular political stance. The WIAS emphasizes how a woman views herself regardless of the role she chooses, consequently, the feminist identity model is subsumed under the womanist identity model in that feminism is only one of many choices a woman can make (Ossana et al., 1992).

Carter and Parks (1996) sought to clarify the relationship between womanist identity attitudes and psychological symptoms among ethnically and economically diverse college students. Of the 218 participants, 76%

(n=147) were white and 31% were African American (n=67). The remaining were Asian, Latina, and Native American but were not included in the analyses. Participants completed the Womanist Identity Attitudes Scale (WIAS), Bell Global Psychopathology Scale, and a personal data sheet. Canonical correlation analyses were performed on the data.

No significant relationship was found between womanist identity attitudes and psychological symptomatology for the African American women in this study, but the researcher wondered whether this finding was related to the smaller sample size. By contrast, immersion-emersion attitudes, and to a lesser extent, encounter and preencounter attitudes in white women were associated with depression, anxiety, paranoia, hallucinations, phobias, obsessions or compulsions, and concerns about alcohol use. Again, the researchers are not clear about the implications of their findings. They offer that the stress involved in the shifts in thinking from the encounter and immersion-emersion stages may contribute to increased symptomatology, but also consider the possibility that the symptoms reported may be reflective of the experiences at these stages, or that women who do not function well may be mired in these earlier developmental stages.

Ossana et al. (1992) investigated womanist identity attitudes, perceptions of gender bias, and self-esteem in

undergraduate women. The majority of the participants were white (78%), with African Americans (13%) as the next largest group. A small number of Asian (8%), Latina (2%), and Native American women (.8%) also took part in the study. The instruments consisted of the Womanist Identity Attitudes Scale (WIAS), Rosenberg Self-Esteem Scale (RSE), Campus Environment Survey (CES), and a demographic data sheet. Regression analyses were performed on the data.

The researchers discovered that preencounter, encounter, and immersion-emersion attitudes were positively correlated with perceptions of gender bias on campus and negatively correlated with self-esteem. Conversely, internalization attitudes were negatively correlated with perceptions of unequal treatment in the campus environment and positively correlated with self-esteem. The latter finding supports the hypothesis that internalization attitudes represent a more positive view of the self.

In a study exploring the relationships among womanist identity, racial identity and self-esteem in African American female college students, Poindexter-Cameron and Robinson (1997) sampled 46 African American women from a predominantly white university and 38 African American women from an historically African American university. Participants completed the Racial Identity Attitudes Scale (RIAS) Long Form, Womanist

Identity Attitudes Scale (WIAS), the Rosenberg Self-Esteem Scale (RSE) and a personal data sheet. Pearson product moment correlation coefficients and chi square analysis were employed for data analysis.

High self-esteem was positively correlated with WIAS and RIAS internalization subscales. The preencounter subscales for the WIAS and RIAS were also positively correlated. However, neither the encounter or immersion-emersion subscales on the WIAS and RIAS were correlated with each other. There was an inverse relationship between preencounter and internalization attitudes; positive gender attitudes did not exist with negative racial attitudes.

RIAS preencounter scores from participants attending historically African American universities were higher than the scores of participants attending predominantly white universities. The researchers posit that students at white institutions may be more actively pursuing a positive African American identity and may be more aware of race due to their minority status at these universities.

The researchers also suggest that the higher WIAS scores of participants from white institutions may be due to a heightened awareness of gender issues. Both groups of women had high self-esteem but women from the predominantly white institutions had significantly higher scores. It was hypothesized that the challenge and

support provided by the white institutions aided these women's overall development and positively affected their self-esteem.

Other researchers have studied womanist and racial identity development in female college students (Parks, Carter, & Gushue, 1996). Sixty-seven African American and 147 white college women completed the Womanist Identity Attitudes Scale (WIAS), Black Racial Identity Scale (RIAS-B), and the White Racial Identity Attitudes Scale (WRIAS). A canonical correlation analysis was used on the data.

A significant positive relationship was found between womanist and racial identity attitudes in African American women. Higher scores on the encounter and internalization subscales of the WIAS were associated with high scores on the internalization subscales of the RIAS. The researchers hypothesized that many African American women begin the process of racial identity development and are aware of racism before they are aware of the effects of sexism, but eventually achieve heightened gender awareness. This finding concurs with other researchers (Hunter & Sellers, 1998; Wilcox, 1997) who discovered that while race was a more prominent issue for African American women, gender concerns were also important for many women.

No significant relationship existed between womanist identity and racial identity in white women in this

study. The researchers speculated that African American and white women face vastly different developmental tasks. Membership in both the dominant racial group and oppressed gender group may account for some of the different experiences and attitudes of white women.

The development of a gender-related identity appears to be a unique process for African American women. Despite a host of challenges, many African American women have developed a positive view of themselves. A better understanding of this developmental process is critical in order to promote healthy development. A positive racial and gender consciousness may serve as a buffer against the multitude of insidious and blatant assaults experienced daily by African American women.

Binge Eating Disorder

Much has been written recently about binge eating disorder (BED) (de Zwann et al., 1994; Eldredge & Agras, 1996; Gladis, Wadden, Foster, Vogt, & Wingate, 1998; Nangle, Johnson, Carr-Nangle, Engler, 1994; Spitzer et al., 1993; Telch, 1997). Although obesity is not a criteria for the diagnosis, the majority of individuals with BED are overweight (Spitzer et al., 1993; Telch, Agras, & Rossiter, 1988). The problem of binge eating was documented in the literature over forty years ago (Stunkard, 1959) but no description of binge eating in the absence of purging appeared in the Diagnostic and

Statistical Manual of Mental Disorders until the 4th edition (APA, 1994).

In one of the earliest large-scale attempts to develop diagnostic criteria for BED and obtain information on prevalence rates, Spitzer et al. (1992) surveyed 1,984 individuals in clinical and community settings. Clinical samples included participants from eating disorder and weight loss treatment programs. Community samples included hospital employees, college students, and persons randomly selected from the telephone book. In addition, members of Overeaters Anonymous (OA), a 12-step program for individuals who report compulsive overeating and other food related problems, participated in the study. The vast majority of the participants were white and female. No information is provided on nonwhite participants. Questionnaires on eating and weight patterns were developed by the researchers.

The clinical samples had a 30% frequency rate of BED. BED was most prevalent in the OA sample, with a frequency rate of 71.2%. Prevalence in the community samples was considerably lower, with a 7% frequency rate. Although episodic overeating was common in the community samples, especially among college students, BED was rare, with only a 2% frequency rate. Of the 19% of the community sample who were obese, 4.4% had BED. More females were found with BED but more males engaged in

episodic overeating in both the clinical and community samples. BED was strongly associated with obesity and a history of weight fluctuation but it was hypothesized that some individuals with BED may be of normal weight.

The researchers concluded that the diagnosis of BED was potentially useful for clinical and research purposes. It was also reported that after reviewing the results of their study, the DSM-IV Work Group on Eating Disorders recommended considering inclusion of BED in the DSM-IV.

In another study, binge eating disorder was investigated to determine whether a history of purging was associated with increased psychopathology, dietary restraint, eating pathology, and disturbance of self-esteem and body image (Peterson et al., 1998). The participants were 63 women of an unspecified race who were already participating in a psychotherapy treatment study and met the criteria for BED. The women were subdivided according to whether they had a history of purging. The Binge Eating Scale (BES), Three Factor Eating Questionnaire (TFEQ), Hamilton Depressive Rating Scale (HDRS), Body Shape Questionnaire (BSQ), and the Rosenberg Self-Esteem Scale (RSES) were used to assess participants. Chi square analysis and analysis of variance were conducted.

The data did not reveal any significant differences between the two BED subgroups on any of the measures. It

was concluded that purging symptoms did not provide a meaningful subgrouping for persons with BED.

Striegel-Moore et al. (1998) attempted to replicate and extend the work of de Zwaan et al. (1994) by investigating binge eating in a community sample of individuals. They also considered the validity of the DSM-IV criteria of twice weekly bingeing for diagnosing binge eating disorder.

The 392 participants were selected from a larger group of obese individuals who responded to a survey about eating behaviors conducted by Consumer Reports. There were four categories of participants: individuals with BED who reported binge eating at least twice weekly; those with sub-threshold BED who reported bingeing at least once a week but less than twice a week; individuals who reported overeating at least twice a week but denied experiencing a loss of control during these episodes; and the control group comprised of persons chosen randomly from a group of individuals reporting less than one overeating episode per month. No information on the participants' race was provided.

A questionnaire designed by the researchers was used to assess body image, weight and diet history and attitudes, and binge eating. It included items from published inventories along with questions developed by the researchers. Demographic information was also collected. In addition, the Rosenberg Self-Esteem Scale

was administered. Lastly, participants were asked to rate their feelings of sadness and stress levels during the past 24 hours and the past 6 months. The data were analyzed using multivariate analysis of variance.

Compared to the control group, obese individuals with BED were found to be more concerned with weight, expressed more dissatisfaction about their weight, and reported greater disparity between their current and ideal body size. The BED group demonstrated significantly lower self-esteem, greater levels of sadness and more stress than all other groups. No significant gender differences were discovered in men and women with BED.

Participants with BED and their sub-threshold counterparts were found to be more similar than different; the researchers concluded that the associated features of each designation were on a continuum, with the higher frequency of bingeing indicating greater severity. In the end, the researchers were not able to determine if there was a more appropriate frequency threshold for diagnosing BED.

Given the plethora of instruments to assess body image, eating behaviors and attitudes, mood disorders, and stress, one has to wonder why the researchers decided to forgo using standardized instruments with documented reliability and validity, and instead used instruments of

their own design. Their assessment choices cast aspersions on what could have been important research.

In a study exploring binge eating, dieting behavior, and psychopathology in an obese clinical population, Grissette and Fitzgibbon (1996) assessed 144 binge eaters and 48 nonbingers. There were 150 women and 42 men; of that number 80% were white, 18% African American, and the remaining 2% were Hispanic, Asian, or other nationalities. All were taking part in a university-based eating disorders program. The assessment measures included the Binge Scale; Borderline Syndrome Index (BSI); Symptom Checklist-90 (SCL-90); Beck Depression Inventory (BDI); Weight History Questionnaire (WHQ); and Dieter's Inventory of Eating Temptations (DIET). Multivariate analysis of variance, chi square analysis, and t tests were conducted on the data.

The researchers made distinctions between individuals who met the full DSM-IV criteria for binge eating disorder (ingesting unusually large amounts of food, loss of control, eating rapidly or when not hungry, distress about eating, etc.) and those who evidenced some but all of the symptoms. Seventy-five per cent (n=144) of the participants engaged in binge eating. Fifty-six per cent (n=107) also indicated associated features such as eating rapidly, eating when not hungry, etc. Forty-two per cent (n=80) reported feeling distressed about their eating. Thirty-eight per cent (n=72) met the full

criteria for BED, indicating they engaged in at least twice weekly binges.

Obese binge eaters were more likely to overeat in response to unpleasant feelings, in social settings, and were less able to resist temptation. They also exhibited significantly higher levels of general distress, depression, and borderline personality traits. In addition, obese binge eaters with BED demonstrated more severe bingeing and higher levels of depression.

Women reported more severe binge eating than men and had a greater tendency to overeat when upset. The data were not analyzed to determine if racial differences existed with respect to binge severity or psychiatric symptomatology. This information could have been extremely valuable, particularly since gender differences were found.

Eating Disorders and African American Women

There are a number of studies that document the presence of eating disorders in nonwhite populations. Researchers who have sampled African American women have found overwhelming evidence of disturbed eating patterns (Anderson & Hay, 1985; Robinson & Andersen, 1985; Silber, 1987; Thompson, 1994a, 1994b; Villarosa, 1994).

Hsu (1987) was one of the first researchers to raise concerns regarding the eating behavior of African American women. Through a series of case studies, he discusses the problems of seven patients, six women and

one man, who were enrolled in an eating disorders program over a 42 month period. Three patients were diagnosed with anorexia, three with bulimia, and one had both anorexia and bulimia. Most of the patients had family histories of mental health disorders and/or alcohol addiction.

Hsu speculates that many African Americans with eating disorders do not come to the attention of health providers or are misdiagnosed. He also postulates that the increased affluence of some African Americans and the adoption of white values may have penetrated African American culture and contributed to a concurrent increase in eating disorders.

In reviewing Hsu's research, it must be noted that binge eating disorder had not been formally diagnosed and received scant attention at the time of his study. Although family histories are noted, nothing else of a contextual nature is provided to inform the reader if other contributors to the disorders exist.

Henriques, Calhoun, and Cann (1996) investigated ethnic differences in women's body satisfaction and whether it was affected by feedback from others. The participants were 97 white and 42 African American female college students who completed the Body Esteem Scale, the Eating Disorders Inventory, and a social rating scale devised by the researchers. Half of the women were randomly given low social rating scores indicating that

other study participants were unfavorably disposed toward them, when in fact, the researcher provided these scores. The other half of the participants were given manufactured positive scores. Statistical procedures included analysis of variance and analysis of covariance.

The African American women were found to have higher body satisfaction, fewer incidences of anorexia and bulimia, and less of a desire to be thin, even though they weighed more than the white participants. African American women were also less affected by the negative or positive opinions of others, leading the researchers to conclude they were less prone to eating problems.

The conclusions of the researchers are questionable. It may be true that many African American women have larger ideal body sizes and are more satisfied with their weight. They may be also less affected by the opinions of some individuals, but body satisfaction doesn't automatically offer immunity from eating disorders. The Eating Disorders Inventory, one of the most widely used instruments to assess eating behaviors, does not permit diagnosis of binge eating disorder. Consequently, important information may be missed.

On the other hand, Fitzgibbon, et al. (1998) homed in on binge eating disorder and assessed African American, Hispanic, and white women in community samples. The researchers also examined the effects of obesity,

depression and perceptions of ideal body size on bingeing severity across the three ethnic groups.

Participants consisted of 179 African American, 117 Hispanic and, and 55 white women whose weight and body mass indices were computed. The women were administered the Questionnaire on Eating and Weight Patterns-Revised (QEWP-R), the Binge Scale, the Beck Depression Inventory (BDI), and the Figure Rating Scale. Hispanic women were also given the Short Acculturation Scale. Demographic information was collected on all participants. Analysis of variance and covariance, chi square analysis, and regression analyses were used on the resulting data.

African American and Hispanic women in this study were heavier than the white female participants. Hispanic women reported more binge eating than African American or white women. A total of 9.6% of Hispanic women tested positively for BED, compared to 3.9% of African American women and 1.8% of white women. Hispanic women also reported more depressive symptoms and slimmer ideal body images than either African American or white women. In all three groups, more severe bingeing was associated with increased obesity and depression. Women who binged more were also found to prefer a slimmer body ideal.

In Hispanic women, body mass index and scores on the depression instrument predicted binge eating severity. For white women, the depression score was the only

significant predictor of bingeing severity, but in African American women, no such relationships were found.

Due to methodological limitations the researchers question whether the participants were representative of the general population and their result generalizable. Even so, 3.9% of African American women with BED is consistent with the 4% figure reported in the National Institute of Health study previously cited (Crute, 1997).

One of the few contextual studies on eating disorders in diverse women was conducted by Thompson (1992). In this qualitative study she interviewed five African American, five Latina, and eight Caucasian women. The sample included heterosexual women and lesbians. The women reported problems with anorexia, bulimia, binge eating and/or compulsive dieting. Fifty per cent of the women were compulsive eaters and dieters, 28% reported problems with bulimia, 17% had bulimia and anorexia, and 5% reported anorexia only. The women associated a host of traumatic experiences including abuse, poverty, racism, sexism, heterosexualism, and acculturation, with the origins of their eating problems.

In using feminist theory, Thompson takes eating disorders out of the realm of individual psychopathology by highlighting the injurious nature of discrimination and economic problems. The researcher conceptualizes eating problems as an adaptive response to powerlessness

and trauma, which encourages an examination of external factors.

The preceding studies illustrate many of the issues surrounding eating disorders and African American women, as well as problems in the research. Research instruments that do not consider binge eating provide incomplete information, and when the context of women's lives isn't considered, the resulting data are likewise incomplete.

Eating Disorders and African American College Women

There are few references in the literature to eating problems in the African American college population. Most of the available studies are reviewed in this section. One can only speculate whether this oversight is due to lack of interest or faulty assumptions on the part of the researchers.

Nevo (1985) conducted a study on bulimia in college women, and included white, Asian, and African American participants. Unfortunately, the number of African American participants was so small they were excluded from the analysis of the results.

One of the earliest studies on eating disorders in African American college students was conducted by Gray, Ford, & Kelly (1987). They looked at the prevalence of bulimia in African American college students and compared the results with an earlier study on white college students (Gray & Ford, 1985). A total of 507 African

American undergraduates from an African American university participated. Two-thirds (n=341) were female.

A questionnaire developed by the researchers was utilized to obtain information on bulimic symptomatology, weight history, body type, and attitudes about weight. Socioeconomic status was also obtained. Chi square analysis was used to compare groups of the same sex.

Few African American women in this study showed signs of bulimia. Their prevalence rates ranged from 1.5% to 3%, depending on the criteria used. These figures are in sharp contrast to the prevalence rates among white females, which ranged from 5% to 13%. No significant differences were found between the groups regarding frequency of bingeing. However, a startling 71% of African American college women reported binge eating, compared to 63% of white college women.

Food and weight concerns were less emphasized by the African American female students, who were also less likely to consider themselves overweight or experience negative feelings regarding food and weight. Differences in the prevalence rates between the two groups were thought to be related to cultural rather than socioeconomic differences.

Body image, body size perceptions and eating behaviors were compared in African American and white college women (Rucker & Cash, 1992). Initially, 120 female students from the same university had been

recruited for the study, but after their body mass indices (BMI) were computed, African American women with very high and white women with very low BMI values were eliminated, resulting in a sample of 49 white and 55 African American participants who were matched for weight and age.

The Multidimensional Body-Self Relations

Questionnaire (MBSRQ); the Body-Image Automatic Thoughts Questionnaire (BIATQ); the Body-Image Avoidance Questionnaire; Goldfarb Fear of Fat Scale (GFFS); Revised Restraint Scale; three subscales of the Eating Disorder Inventory (Drive for Thinness, Bulimia, and Body Dissatisfaction); the Body Image Assessment Procedure (BIAP); and the Perceptions of Fatness Procedure, which was developed by the researchers, were the assessments used in this study. Multivariate analysis of variance and univariate analysis of variance were employed to analyze the data.

Relative to white women, African American women reported less body dissatisfaction, less negative thoughts about their bodies, and more positive evaluations of their appearance. White women exhibited a greater fear of fatness, stronger drive to be thin, and more diet and weight concerns. African American and white women did not differ significantly on perceptions of current body size but more white women desired a thinner body. No significant differences were found

between the groups on the EDI bulimia scale, with scores falling within the normal range. However, the researchers reanalyzed the scores to detect subclinical eating patterns and found greater eating dyscontrol among the white female participants, suggesting they were at greater risk for developing eating disorders.

While the researchers contend that they protected the internal validity of their study by eliminating outliers with very high or low BMI scores, the opposite may have occurred. Selectively choosing their participants may have drastically altered the results and thereby compromised the validity of this study. Perhaps the extreme BMI scores in African American and white women are more reflective of what exists in the general population.

A study by Abrams, Allen, and Gray (1992) explored eating behaviors in African American and white female college students. The relationship between identification with white culture and eating disorders was also considered.

One hundred African American females and 100 white females attending the same university took part in the study. African American and white participants were similar in age, height, and socioeconomic status, but the two groups varied considerably in weight, with the African American participants being heavier. Participants completed the Binge Scale, Eating Disorders

Inventory (EDI), Restraint Scale, Beck Depression Inventory (BDI), Rosenberg Self-Esteem Inventory, State-Trait Anxiety Inventory, Form Y-2 (STAI), and the Racial Identity Attitudes Scale for Blacks (RIAS-B). Analysis of covariance and chi square analysis were used on the data.

Although heavier than their white counterparts, African American college women were less concerned with weight loss and made less effort to be thin. African American college women were also less likely to engage in severe restrictive dieting, bingeing, or purging than the white college women in this study.

African American women at the preencounter stage of the RIAS (rejecting African American identity and identifying with white culture) scored higher on dietary restraint, fear of fat, and drive for thinness measures. For both groups of women, the aforementioned three measures were correlated with depression, anxiety, and low self-esteem. Binge eating was significantly related to depression only in the white participants.

The findings of the previous research study differ from those of Dinsmore and Mallinckrodt (1996) who examined emotional self-awareness, eating disorders, and racial identity in African American college women. Their data revealed that preencounter attitudes were associated with more difficulty in identifying and expressing feelings and internalization attitudes were associated

with less difficulty in labeling and expressing feelings. There was, however, no relationship between racial identity and eating disorders, or eating disorders and emotional self-awareness.

Akan and Grilo (1995) investigated similar issues with respect to eating patterns, body image, and self-esteem in African American, Caucasian, and Asian female college students. While none of the participants met the full criteria for an eating disorder, there were significant differences among the groups on some of the eating-related measures. The African American women weighed more but had higher self-esteem, and the Caucasian women reported more problematic eating behaviors and attitudes. The degree of acculturation and assimilation experienced by the African American and Asian was not related to eating behavior or body image.

Lester & Petrie (1998) examined the relationships among body mass, body satisfaction, depression, self-esteem, perceptions of attractiveness, identification with white culture, and bulimic symptomatology in African American female college students. Study participants consisted of 123 African American women who were enrolled in three predominantly white colleges. Undergraduates and graduate students were included in this sample.

The following instruments were used: The African American Acculturation Scale-Short Form (AAAS-SF); Beliefs About Attractiveness Scale-Revised; Body Parts

Satisfaction Scale; Center for Epidemiologic Studies Depression Scale (CES-D); Rosenberg Self-Esteem Scale; and the Bulimia Test-R (BILIT-R). Demographic information was collected along with information on height and weight.

Pearson product-moment correlations, t tests, and regression analyses were the statistical procedures used. Scores on the BULIT-R were compared to scores from a sample of predominantly white women (Johnson & Petrie, 1996) who attended one of the universities from which African American participants were recruited. There was no significant difference in the two groups on this measure.

Body mass, body dissatisfaction, and low self-esteem were found to be the best predictors of bulimic symptomatology. Internalization of white values regarding attractiveness and identification with white culture were unrelated to bulimic symptoms.

The researchers chose a number of relevant variables to investigate and their methodology appears sound. Nevertheless, they do not disclose the percentage of women in either group who exhibited bulimic symptoms, but merely report the mean scores of the groups without discussing their implications with respect to diagnosis or prevalence rates.

In considering this group of studies as a whole, it must be remembered that only one of the studies employed

an instrument specifically designed to assess bingeing in the absence of purging. Many of these researchers suggest that less concern about body size protects African American women from eating problems, a notion which has already been disproved. Rucker and Cash (1992) offer another view by suggesting that a more relaxed attitude about weight may offer some protection against anorexia and bulimia, but may put African American women at greater risk for obesity.

It should also be noted that in one of the studies that considered racial identity in relation to eating behavior (Abrams et al., 1992), African Americans who were more strongly identified with white culture and values demonstrated significantly more concerns about weight and were more likely to experience depression, anxiety, and low self-esteem. This finding is consistent with researchers cited earlier (Henriques et al., 1996; Hsu, 1987; Villarosa, 1994) who concluded that greater identification with white standards, often brought about by more contact with the dominant culture, is associated with a greater value placed on thinness and increased risk of unhealthy eating behaviors.

If eating disorders are less prevalent in the African American female college population, more information is still needed to understand this phenomenon. It is really that African American college women have less eating disorders than white college women

or that the type of eating problems differ? How do the eating patterns of African American college women vary from African American women in the general population? These questions must be answered if we are to fully comprehend and adequately treat African American women with eating problems.

Depression in African American Women

Despite conflicting information on prevalence rates and the scarcity of data, the literature does suggest that depression in African Americans in general, and women in particular, is a serious problem (Brown et al., 1995; Murrell, Himmelfarb, & Wright, 1983; Ulbrich, Warheit, & Zimmerman, 1989). Researchers have determined the greatest risk factors for depression in African Americans were gender, with women being substantially more depressed; marital status, with single individuals being more vulnerable; and low income or unemployment (Dressler, 1986; Dressler & Badger, 1985). In addition, it appears that African Americans who are lesbian or gay are especially at risk (Cochran & Mays, 1994).

Reed et al. (1996) examined the prevalence of depression in a sample of 78 African American college women. Participants were assessed with the MMPI-2, Ways of Coping Checklist, Beck Depression Inventory, and the State-Trait Anxiety Inventory. Correlations and stepwise regression analyses were performed.

Fifty-eight per cent of the women were depressed according to the BDI, but 23% were given a diagnosis of depression with the MMPI-2 scale, which is considered a more conservative gauge of depression level. However, both measures identified the same individuals as being more severely depressed.

Individuals who experience high levels of depression had significant trait anxiety. Individuals with better coping skills and support systems had less depressive symptomatology. The researchers also noted that many African Americans lead stress filled lives with little or no environmental support and speculated that this contributed to depression in many individuals. This study is especially pertinent due to its sample of African American female college students and its consideration of social and environmental factors.

In a study examining ethnicity, gender, social support, and depression in older workers, Fernandez, Mutran, Reitzes, and Sudha (1998) sampled 749 individuals between the ages of 58 and 64. The participants consisted of 303 (40.4%) white men, 318 (42.4%) white women, 54 (9.2%) African American men, and 74 (9.9%) African American women. The Center for Epidemiologic Studies Depression Scale, (CES-D), an unnamed checklist of stressful life events, and a measure of social support designed by the researchers were used to assess participants. In addition, information was collected on

participants' income, education, physical health, and retirement status. Analysis of variance and chi square analysis were used to compare the data.

Researchers discovered that white men had the highest levels of social support, income, and education, while African American women had the lowest levels. African American women also had significantly more depressive symptoms than white men or women, and despite educational levels similar to white women and African American men, African American women had the lowest household incomes. Income level was found to significantly influence depressive symptoms and the effects were greatest for African American women. The researchers concluded that satisfying relationships, higher incomes, higher educational levels, and better health were inversely related to depression. The results of this study speak volumes about the many external factors which impinge upon the well-being of African American women.

Carr, Gilroy, and Sherman (1996) examined whether "silencing the self," the process of ignoring, denying, or discounting one's feelings and needs in deference to others, contributed to depression in African American women to the same degree that it affects white women. Their sample consisted of 80 women, with an equal number of African American and Caucasian participants who were all community college students. Participants completed

the Silencing of the Self Scale, Beck Depression Inventory, and Marlowe-Crowe Social Desirability Scale. Multiple regression analyses were performed.

The results indicated that race moderated the relationship between silencing the self and depression. Although African American women silenced themselves to the same degree as Caucasian women, the degree of silencing was highly correlated with depression in Caucasian women but not in African American women. The researchers speculated that other factors must contribute to depression in African American women. Even though the researchers do not mention environmental stressors, they do suggest that different processes are at work in the experience of depression in women of color.

These findings are in contrast to the results of a study by Gratch, Bassett, and Attra (1995), who looked at self-silencing by gender and ethnicity in a group of African American, Caucasian, Hispanic, and Asian adults. Men in this study silenced themselves more than women, and Asian Americans of both sexes engaged in more self-silencing than any other ethnic group. Women were more depressed than men, and African American, Asian, and Hispanic women experienced comparable levels of depression, which were significantly higher than in Caucasian women. A significant, positive correlation was found between self-silencing and depression, particularly in African American and Caucasian women. The researchers

speculated that a combination of cultural norms and variations in power and status of the groups may account for many of the differences. The conclusions of these researchers affirm the utility of viewing individuals within a wider context.

The American Psychological Association's National Task Force on Women and Depression (McGrath et al., 1990) did no original research but evaluated and synthesized the findings of hundreds of research studies in order to assess risk factors for depression in women and determine treatment needs. The Task Force considered the needs of women of different ethnicities, ages, income levels and sexual orientations. They also addressed the role of sexual abuse, poverty and other traumatic experiences in the development of depression, which was also related to substance abuse and eating disorders.

The Task Force found that depression was the most prevalent mental health problem for all women, regardless of race. Particularly high rates of depression were discovered among poor women and those who had been victimized. It was hypothesized that for some women, depressive symptoms may be the long-standing effects of posttraumatic stress syndrome. Depression was frequently observed in women with eating disorders, and similarities were found in the neurochemistry of women with these disorders. McGrath and colleagues advocated for the sociopolitical perspective of feminist theory in

understanding and treating depression. They also recommended more research on a number of issues, including depression in women of color, and emphasized the importance of acknowledging culture and racial identity issues in treating diverse women.

The aforementioned studies provide some indication of the complexity of issues that require consideration in discussing depression in African American women. For a complete picture, the individual's inner and outer state must be examined.

Eating Disorders and Depression

Many researchers have discovered a connection between eating disorders and mental health problems. Individuals with eating disorders are prone to psychiatric disorders, particularly depression (Fava et al., 1997; de Zwaan et al., 1994; Kuehnel & Wadden, 1994; leGrange et al., 1997; Marcus, Wing, & Hopkins, 1988; Mussel et al., 1995).

Grubb, Sellers, and Waligrowski (1993) investigated the connection between eating disorders and depression. The participants were 42 female college students. No information was provided on race. The women were measured with the Eating Disorders Inventory (EDI), Beck Depression Inventory (BDI), Coopersmith Self-Esteem Inventory, and the Body Image/Attractiveness Perception Scale.

Pearson correlations indicated a significant positive relationship between scores on the BDI and five subscales of the EDI, namely, Drive for Thinness, Body Dissatisfaction, Ineffectiveness, Perfectionism, and Maturity Fears. The highest correlation was for Ineffectiveness, with a score of .62. The only significant correlation found between the self-esteem and eating disorder scales was on the EDI subscale for Perfectionism. Scores on the self-esteem inventory were not correlated with the depression inventory. Depression scores were inversely related to body size but were unrelated to self-rated attractiveness.

A study by Willcox and Sattler (1996) also examined the relationship between eating disorders and depression. Using a sample of 107 female college students whose race was unspecified, they administered the short form of the Multiscore Depression Inventory (MSDI) and the Eating Disorder Inventory (EDI). Scores on the SMDI and the EDI were positively correlated.

Bulimia was related to depression and low self-esteem. Drive for Thinness was linked to depression and low energy level. Guilt was also suspected to play a role in eating disorders. Most of the correlations, however, were weak to moderate. The EDI factors rarely accounted for more than 10% of the variance.

Another study (Marcus et al., 1990) attempted to determine differences between obese binge eaters and

obese nonbingers with respect to psychiatric symptoms. The researchers noted that bulimics of normal weight have a high lifetime prevalence rate of mood disorders (Lee, Rush, & Mitchell, 1985). Other investigators have found that women with bulimia and women with depression share the same overall maladaptive cognitive style, and the pattern of individual cognitions and beliefs is the same (Phillips, Tiggeman, & Wade, 1997). Obese binge eaters are similar to bulimics of normal weight (Marcus & Wing, 1987), with both groups exhibiting marked dietary restraint, weight preoccupation, and rigid and perfectionistic attitudes about eating. Based on these findings and their previous work (Marcus et al., 1988) Marcus et al. (1990) speculated that obese binge eaters would have higher rates of mood disorders.

The participants who were binge eaters were identified through the use of the Binge Eating Scale (BES). Twenty-five binge eaters and 25 nonbinge eaters were randomly selected from the same age, weight, and sex groupings, resulting in a sample of 44 females and six males. Information on ethnicity was not provided. Participants were interviewed using the National Institute of Mental Health Diagnostic Interview Schedule, Version III (DIS). Comparisons between groups were made using two-tailed Fisher's exact tests and Student's *t* tests.

The results showed that 60% of binge eaters met the criteria for at least one psychiatric disorder, compared to 28% of the nonbinge eaters. In addition, 32% of bingers met the criteria for mood disorders, compared to 8% of nonbingers. Six bingers (24%) met the criteria for major depression but only one nonbinger (4%) fell into this category. An additional two binge eaters (8%) met the criteria for dysthymia, compared to one nonbinge eater (4%). Binge eaters also exhibited higher rates of anxiety disorders and reported greater sexual dysfunction.

A study by Kensinger et al. (1998) described psychological and behavioral differences between overweight female weight cyclers (individuals exhibiting a pattern of losing weight and later regaining it) who binge eat and overweight female weight cyclers who do not binge. Further distinctions were made between weight cyclers with no binge eating to moderate binge eating, and those with severe binge eating.

Sixty-two women with a body mass index greater than 27.3 participated in this research project. Their race is unknown. Binge eating was assessed with the Binge Eating Assessment Scale. Participants also completed the Symptom Check List-90-R (SCL-90-R), measuring psychiatric symptoms; the Beck Depression Inventory (BDI); Rosenberg Self-Esteem Scale; Three Factor Eating Questionnaire (TFEQ), a measure of cognitive restrained eating, hunger

and disinhibition; Eating Self-Efficacy Scale, which reports the individual's assessment of his or her ability to control overeating; and the Ways of Coping Check-List-Revised (WCCL-R). Scores on the instruments were compared between bingers and nonbingers, and according to severity. Student's t tests and the Mann-Whitney U test were used to compare group means.

The researchers discovered that 36 (58%) of the weight cyclers met the criteria for binge eating disorder. Weight cyclers with binge eating disorder and severe binge eaters were more likely to overeat in response to emotional triggers than weight cyclers with no binge eating or who fell in the no eating disorder to moderate eating disorder category. Weight cyclers with severe binge eating had less dietary restraint than weight cyclers with no binge eating to moderate binge eating. All participants had poor eating self-efficacy. Weight cyclers with binge eating disorder and those with severe binge eating reported greater difficulty controlling their eating. Severe binge eaters were less likely to use healthy coping strategies, had low self-esteem and greater psychological distress.

No significant differences were observed on the BDI between weight cyclers with and those without binge eating disorder but severe binge eaters had higher scores for depression. The researchers suggest that individuals

with severe binge eating problems should be routinely screened for depression.

These studies demonstrate a sufficient connection between eating disorders and depression to warrant further investigation. It is particularly significant that when binge eating is investigated, it is highly correlated with psychiatric symptoms.

Although the ethnicity of participants in all the studies was not disclosed, one can safely assume that where no race was specified, the samples were predominantly if not exclusively white. It is critical therefore, to explore these issues with women of color to discover any differences or similarities.

African American College Students

Although African American college students face many of the same developmental tasks as white students, students of color at white institutions encounter additional obstacles such as discrimination, adjusting to what is for some a foreign culture as well as adjusting to college life, greater financial concerns, feelings of loneliness and isolation, and limited social and cultural outlets (D'Augelli & Hershberger, 1993; Fisher & Hartmann, 1995; June, Curry, & Gear, 1990; Neville, Heppner, & Wang, 1997). Many of the stressors do not dissipate over time (June et al., 1990) and can negatively impact psychological health (Jung & Khalsa, 1989). It has been hypothesized that African American

students' experiences with racism and their perceptions of the campus environment mediates the relationship between their academic and actual achievement (Mallinckrodt, 1988; D'Augelli & Hershberger, 1993). Not surprisingly, African American students drop out of college at higher rates than white students (Allen & Strong, 1996; D'Augelli & Hershberger, 1993) but it is not clear to what extent low retention rates may be related to these stressors.

As early as the 1970s when large numbers of African American students began attending predominantly white universities, Sowell (1972) expressed grave concern about the experiences of African American students at these institutions. More recent studies have explored student adjustment (Gerdes & Mallinckrodt, 1994; Thompson & Fretz, 1991) and the role of environmental influences on degree attainment (Crosson, 1992; Mallinckrodt, 1988).

The benefits of white versus African American institutions of higher education have been examined (Fleming, 1984). The researcher determined that white universities, while offering greater resources than many African American institutions, are often perceived by African American students as being hostile and less supportive.

Fleming (1983) also studied African American female college students and found that women reported feeling comfortable and supported at African American

institutions. This environment promoted academic achievement while at the same time encouraging passivity in social situations. On the other hand, the negative circumstances encountered in white institutions, such as isolation, lack of partners for heterosexual relationships, and lack of institutional support, made for unhappy experiences but promoted confidence and assertiveness in African American women.

Launier (1997) considered the impact of stressors on the emotional life of African American college students from historically African American institutions. The sample consisted of 200 students. Sixty-six per cent were female and the median age was 20. Participants completed the Emotology Q-Deck (EQD), a Q-sort measure to assess emotional life and stress balance; a questionnaire to measure lifestyle health habits; and the Pessimism-Optimism Scale. The emotional stress balance (ESB), a measure of the magnitude and direction of the stress, was computed to determine the relative balance between stress-free and stressful emotions experienced by participants.

The researcher discovered that most participants enjoyed healthy emotional lives. The average stress balance was 67%, meaning 67% of the emotions experienced were positive. However, there were distinct sources of stress that impacted on the students. The most common and severe source of stress was financial, which was

inversely correlated with emotional well-being. Participants without adequate financial resources reported greater feelings of desperation, anger, depression, frustration, loneliness, anxiety, worthlessness, and resentment.

Experiences of racial discrimination (which presumably occurred off campus) also negatively affected participants' emotional stress balance and caused significant impairment. Gender differences were observed. Men reported less racial discrimination but exhibited more somatic complaints when they did experience racial distress. Women reported more instances of racial discrimination and experienced greater emotional distress. As a result of these findings, educational, economic, and cultural interventions are recommended.

This study sheds additional light on the deleterious effects of poverty and racism and supports the notion that African American women experience the same phenomena differently from other groups. African American women in this study had vastly different experiences and different responses to those experiences.

Racial identity attitudes, perceived stressors, and coping styles of African American students at predominantly white universities were examined in a study by Neville, Heppner, and Wang (1997). The participants were 90 African American undergraduates who completed the

Racial Identity Attitudes Scale-Long Form (RIAS), a modified version of the Black Student Stress Inventory, the Problem Solving Inventory, and the Problem-Focused Style of Coping. Multiple regression analyses were performed on the data.

On the whole, participants reported few general and culture specific stressors. The stressors reported, however, were significantly correlated with the RIAS subscale scores and coping styles. Higher scores on the immersion-emersion subscales of the RIAS (indicating pro-African American and anti-white attitudes) were associated with greater general and culture-specific stress, low problem-solving appraisal, and low problem-focused coping. High internalization scores on the RIAS (indicating a positive racial identity) were associated with greater problem solving appraisal. As in other studies, high internalization scores suggested greater psychological adjustment. The researchers concluded that African American students at predominantly white institutions face many of the same challenges as other students but are also faced with unique, culture-specific stressors. A number of recommendations were made to support African American students and nurture positive racial identity attitudes.

A study on the impact of minority status as a stressor, and its relationship to college adjustment on students of color was conducted by Smedley, Myers, and

Harrell (1993). The sample consisted of 161 college freshmen of color attending a predominantly white university. There were 45 African Americans, 54 Chicanos, 25 Latinos, and 37 Filipinos, which included 114 females and 47 males. Students completed the Life Events Survey for College Students, the Current Concerns Scale, Minority Student Stress Scale, Hopkins Symptom Checklist, and eight items from the General Well-Being Questionnaire. Analysis of variance and regression analyses were used.

African American students reported significantly higher mean levels of social climate stress, within-group stress, interracial stress, and more racism and discrimination stress than the other ethnic groups. Females reported significantly higher levels of achievement stress. Overall, minority status stress was an additional burden for students of color and was associated with higher psychological distress. For some students the stressors negatively affected academic achievement. These findings concur with Ancis, Sedlacek, and Mohr (2000) who discovered that African American students experienced more racial hostility, stereotyping, and less equitable treatment by faculty and staff, compared to white students and other students of color. However, despite their findings, Smedley et al. (1993) suggested that academic aptitude and preparedness contributed more to academic achievement. They also

suggested that the effects of minority status stress may be mediated by factors such as racial identity and a sense of group solidarity.

Cabrera et al. (1999) studied the effects of perceptions of prejudice and discrimination on college adjustment in African American and white freshmen at predominantly white colleges. Their sample was made up of 1,139 white students and 315 African American students. Measures developed by the researchers included the Interaction with Faculty scale, Interactions with Peers scale, and an adaptation of a campus/racial climate scale. An unnamed measure to assess intellectual ability based on constructs developed by four of the researchers was also used. In addition, high school and college grade point averages, and student enrollment information were utilized. Correlation coefficients and t-tests were computed.

It was discovered that perceptions of prejudice and discrimination negatively affected white students as well as African Americans, although African Americans were more profoundly affected. The researchers also concluded that both groups adjusted to college in a similar manner. They contend that persistence for both groups was determined by preparation for college, positive academic experiences, strong parental support, and academic performance.

The conclusions of Cabrera et al. (1999) differ substantially from other researchers, such as Smedley et al. (1993). There are a number of points of concern and one wonders how their conclusions were derived. First, the preponderance of researcher developed instruments in this study is suspect, particularly since no information on reliability and validity is provided. Secondly, the researchers do not utilize all of their own data to consider the potentially traumatic nature of discriminatory experiences and how that might affect adjustment. As documented earlier, additional stressors such as racism profoundly change the adjustment process and overall experience of African American students, even in those who persist and complete their education.

For example, in a study of juniors and seniors at a predominantly white university, D'Augelli and Hershberger (1993) matched African American and white students academically and found that differences in their personal backgrounds and experiences on campus rather than academic preparation accounted for the distinctly different perceptions and attitudes of the two groups. African American students entered college with fewer resources, and were required to make greater personal, family, and social adjustments than white students. That African American students judged the university more negatively was attributed to their experiences with racism.

Even though these African American students were successful academically and in all likelihood would graduate, being in a foreign and inhospitable environment colored their experience. It seems obvious that researchers must concern themselves with more than retention and must also consider the psychological effects of the many unique and ongoing stressors with which African American students must contend.

More research is warranted to fully capture the experience of African American students, particularly females, since it was found that college women of color experience more discrimination and feel greater pressure to achieve. It may also be helpful to learn whether the stress that African American female students experience at predominantly white universities contributes to the development of eating disorders and/or depression, and whether the prevalence rate is the same at African American universities.

Summary

In this chapter relevant literature was reviewed on the subjects of feminist theory, womanist identity, eating disorders, and depression as they relate to African American women. Studies on African American college students were also considered.

Black feminist thought serves as the theoretical framework for this study. At the crux of this theory are the beliefs that African American women are oppressed due

to gender, race, and economic status, have a different vantage point from African American men or other groups of women, and must be the architects of their own liberation. African American women have a long history of struggling for their rights.

Walker (1983) popularized the term "womanist" to describe feminists, particularly feminists of color. This term was adopted by Helms (Ossana et al., 1992), who translated the concept of womanist identity into an inventory assessing attitudes about gender. A positive gender identity is associated with high self-esteem and mental health, and is considered in this study as a possible protective factor against eating disorders and depression.

Binge eating disorder, while not recognized by the DSM-IV as a full-fledged eating disorder, has been given a great deal of attention in the literature recently. Most binge eaters are overweight and are more prone to weight fluctuations, negative body assessments, low self-esteem, and mood disorders, particularly depression.

Binge eating disorder is the most common eating problem affecting African American women, who are often not included in studies on this disorder. The false assumption that African American women are not subject to eating disorders has greatly hindered research, diagnosis, and treatment. Even among African American women who do not meet the full criteria for BED, many

admit to periodic bingeing. The unhealthy eating behavior of African American women is associated with the powerlessness and trauma that is all too common in the lives of many women.

There is a dearth of research on the eating behaviors and attitudes of the African American college population, and the available studies focus primarily on bulimia. That there are no documented studies on binge eating in African American college students leaves many unanswered questions.

Depression in African American women is a serious problem and is correlated with poverty, discrimination, sexual abuse and other forms of victimization. One of the few studies on African American college women found high levels of depression and environmental stress.

The association of binge eating disorder with depression has already been noted, and a number of researchers have discovered a relationship between other eating disorders and depression. This link has not been explored with respect to African American women in general, or specifically, African American female college students. Since African American women are prone to both eating disorders and depression, it stands to reason that some may exhibit both disorders. The stress that African American college women face, particularly at white universities may be a factor in the development of these disorders.

African American women have a unique history and face a number of severe obstacles which can negatively impact their well being and overall functioning. Yet despite enormous challenges, they are amazingly resilient. Individuals, however, vary in the types of stressors they encounter and their ability to manage adversity. Due to the devastating effects of racism and oppression, eating problems and depression must be acknowledged, specialized strategies developed to address these issues, and gaps in the literature must be filled. Since African American women are not a variation of white women and are dissimilar in some respects from other women of color, the research and interventions must be targeted specifically for them. African American female college students must be given special consideration since they face unique challenges.

The present study was designed to help fill the gaps in our knowledge about African American college women with eating disorders and depression. This study significantly adds to the literature on both disorders.

The following chapter describes the methodology for the study in detail. Standardized instruments were utilized in order to explore the relationships among eating disorders, depression, and womanist identity in African American college women.

CHAPTER 3
METHODOLOGY

Research Questions

The following questions were explored in this study:

1. Do African American female college students have eating disorders in the same proportion as white female college students?
2. Is binge eating disorder the most common eating disorder in African American female college students?
3. What is the relationship between eating disorders and depression in African American female college students?
4. Is there a relationship between womanist identity and the development of eating disorders or depression in African American female college students?

Population and Sample

The population of interest was African American college women in the US. The sample for this study was comprised of African American female undergraduate volunteers attending one predominantly white university (PWU) and one predominantly African American university (PAAU) in central Virginia. Due to financial and time constraints, convenience sampling was employed. A total of 70 participants were obtained.

Members of campus groups containing African American

women were recruited at the predominantly white university. These organizations included sororities, choirs, social clubs, and other cultural organizations. In addition, participants were recruited from athletic teams. Help in recruiting was also solicited from faculty of color.

This researcher contacted the various student groups, staff, and professors to ask for permission to attend a meeting or class in order to explain the study, answer questions, and recruit participants. In some cases the researcher administered the instruments at that time and in other instances made arrangements to administer them on another occasion. Efforts were also made to contact any individuals who missed appointments and reschedule them.

In addition to presentations at closed meetings of campus organizations, an informal talk that was open to the public was held on "African American Women and Stress." This activity enabled the researcher to engage students who did not belong to groups. After the presentation and discussion, instruments were administered to all consenting students who fit the criteria for inclusion in the study. Thirty-four participants were obtained from the PWU.

At the predominantly African American university nursing students were recruited. With the assistance of

the nursing faculty, the researcher sampled thirty-six undergraduate women.

Initially, the researcher planned to obtain participants solely from the predominantly white university. Many attempts were made to recruit women from various campus organizations with African American female members. However, many of the women belonged to multiple organizations so that the researcher encountered the same individuals repeatedly. These women constitute the majority of the sample from the PWU. Rather than obtaining a representative sampling of African American women at the university, this sample is made of what appears to be an elite group of "doers and joiners." Efforts to recruit additional participants from other sources such as undergraduate classes were less successful. Due to the small number of participants obtained from the PWU, a decision was made to recruit participants from a predominantly African American university.

Since the PWU participants, who were initially the target population for the study, were a fairly homogeneous group, demographic data was limited to age and income. These women were all single, childless, and dependent on parents or guardians for financial support.

It was surprising therefore, to learn that some of the participants from the PAAU were married, had children, and were self-supporting. Unfortunately, this

discovery came too late to collect information on these variables. The demographic data that was collected revealed that this sample was significantly older than the sample at the PWU.

Data Collection

This study made use of the Beck Depression Inventory II (BDI), Eating Disorders Inventory-2 (EDI), Binge Scale, and the Womanist Identity Attitudes Scale (WIAS). In addition, demographic information, such as age and income level, was obtained.

A copy of the demographic information form is provided in Appendix A. Copies of other tests used are also included in the appendices, except where forbidden by the test manufacturers.

Information on participants remained confidential, but participants were not anonymous. This enabled the researcher to identify any individuals with severe depression or eating problems and refer them to the counseling center at their institution.

Group administration of the assessments occurred whenever possible. This was not contraindicated with the instruments that were used. Individual appointments were held only if a participant was unable to attend any group session.

Qualitative Component

The purpose of the qualitative portion of the study was to give participants the opportunity to share about

their experiences with eating disorders in an in-depth manner. It was made clear that this activity was optional to ensure that participants would not feel coerced into being interviewed. All potential interviewees were assured that confidentiality would be maintained.

A phenomenological approach was to be utilized in which the researcher attempted to understand how different individuals interpreted the experience of being an African American female student and their experiences with binge eating disorder.

The researcher estimated that between three and five participants would take part in the qualitative component. A qualitative questionnaire was developed by the researcher and pilot tested beforehand with African American female students.

It was planned that all of the interviews would be audiotaped and transcribed. The researcher would have then engaged in member checking with the respondents to insure the accuracy of the material obtained.

Disappointingly, no participants agreed to be interviewed for this portion of the study. Possible reasons for the refusals will be discussed in chapter 5.

Instrumentation

Eating Disorder Inventory

Garner (1991) developed the Eating Disorder Inventory-2 (EDI) to assess symptomatology associated

with anorexia and bulimia. It is a self-report measure which uses a six-point Likert-type scale. This instrument contains 91 statements regarding eating behavior. Responses range from "always," "usually," "often," "sometimes," "rarely," to "never." The subscales measure Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Introceptive Awareness, and Maturity Fears.

Responses for each item range from 0 to 3, with the higher score indicating more symptomatology. Raw scores for the EDI subscales are plotted on profile forms in order to compare the score to the appropriate norming group.

Norms are available for clinical and nonclinical populations, including male and female college students, high school students, and adolescent girls ages 11 to 18. No information is available on the ethnicity of the norming groups.

With respect to reliability, the subscales had internal consistency scores ranging from .70 to .92. After a one week interval, test-retest reliability scores were from .67 to .95 on the different subscales. After a three week period, the scores ranged from .65 to .97 and after one year the range was from .41 to .75.

Content validity was established by clinicians who were familiar with the research literature on eating

disorders and involved in patient care. The author points to the fact that test items and subscales are able to distinguish between clinical and nonclinical samples as evidence of criterion validity. The establishment of concurrent validity entailed comparing clients' self-report profiles with the assessments of clinicians who were familiar with the clients' clinical presentation. The author established construct validity by demonstrating convergent validity and showing that several of the EDI subscales overlap conceptually with the self-report measures administered as part of the initial validation.

Binge Scale

Hawkins and Clement (1980) developed the Binge Scale to assess binge eating with or without purging. A nine-item version of the instrument was used as a result of correspondence with Dr. Hawkins, who stated that only the nine-item version had been validated. A copy of this instrument is provided in Appendix B.

However, in the initial study, Hawkins and Clement describe a 19-item self-report instrument which was pilot tested with college students. It includes questions such as "Do you ever vomit after a binge?" and "How much are you concerned about your binge eating?"

Scores on the Binge Scale range from 0 to 24, with higher scores indicative of more bingeing. It has been suggested that scores of 10 or less reflect normal eating

patterns but scores of 15 or greater indicate an eating disorder (Pike, Loeb, & Walsh, 1995).

Hawkins and Clement (1980) reported that internal consistency was achieved by Chronbach's alpha, with a score of .68. Test retest reliability after one month yielded a score of .88. In addition, the researchers found that 71% of the variance was attributed to one factor relating to concern about binge eating. Concurrent validity was established through correlation of the Binge Scale with the Bulimia Test-Revised (BULIT-R), another instrument which assesses bingeing and purging behavior. A .93 correlation existed between the instruments. The Binge Scale also offered good predictive validity, and was particularly helpful in identifying subclinical cases, situational binge eaters, and bulimics (Pike, Loeb, & Walsh, 1995).

Beck Depression Inventory

The latest version of the Beck Depression Inventory (BDI) (Beck et al., 1996) is a 21-item instrument that detects the presence of depression and severity of symptomatology. It is appropriate for use with clinical and nonclinical populations. Respondents are asked to choose one of four statements that best describes their present affective state. Items are rated from 0 to 3, with total scores ranging from 0 to 63. Higher scores indicate more serious levels of depression.

A review and meta-analysis of studies on the BDI (Beck et al., 1988) found a mean internal consistency estimate of .87 for clinical samples and .81 for nonclinical samples. Test-retest reliability over periods of time ranging from several hours to several weeks were from .48 to .86 in clinical samples and .60 to .83 in nonclinical samples. Concurrent validity was established by strong correlations between the BDI and other measures. Clinical ratings had a mean correlation coefficient of .73 with the BDI. The BDI and MMPI Depression Scale produced a mean correlation coefficient of .76.

Womanist Identity Attitudes Scale

The Womanist Identity Attitudes Scale (WIAS) was developed by Helms (Ossana, Helms, & Leonard, 1992) to assess women's beliefs and attitudes about gender and is based on the models of racial identity development by Cross (1971) and Helms (1984). The WIAS delineates four stages of female identity development, namely, Preencounter, Encounter, Immersion-Emersion, and Internalization. There are subscales corresponding to each stage of development. A copy of the instrument is provided in Appendix D.

Examples of statements on the instrument include "In general, I believe that men are superior to women" and "Being a member of the female sex is a source of pride for me." This 44-item inventory employs a Likert-type

scale, and possible responses on the WIAS range from 1, indicating "strongly disagree" to 5, indicating "strongly agree." The respondent's scores for the subscales are summed and averaged in order to ascertain the woman's stage of identity.

One study of the instrument (Ossana et al., 1992) reported internal consistency reliability coefficients using Chronbach's alpha, based on a sample of 659 ethnically diverse female undergraduates. Scores for the subscales were as follows: Preencounter, .55; Encounter, .43; Immersion-Emersion, .82; and Internalization, .77.

Qualitative Questionnaire

A questionnaire was developed by the researcher for the qualitative portion of the study in order to gain information on the experience of binge eating disorder. A phenomenological approach was planned. This methodology considers multiple perspectives in describing one phenomenon or event. There are no standardized tests as the researcher is the instrument. He or she relies on inductive reasoning and the emic perspective, and makes no attempt to control bias (Creswell, 1992, 1998).

This questionnaire consists of 10 open-ended questions and was to be used in semi-structured interviews with three to five participants who reported binge eating. A copy of the questionnaire can be found in Appendix E.

Research Design

A mixed designed was planned for this descriptive study, employing both quantitative and qualitative methods. In the quantitative component, a correlation coefficient, chi square analysis, and discrimination analysis were planned to analyze the data. Unfortunately, due to the lack of cooperation on the part of participants, it was not possible to implement the qualitative component. The lack of variability in the scores on the womanist identity assessment measure precluded the possibility of performing a discriminant analysis. Consequently, a quantitative study was conducted, with only chi square analysis, t-tests, and correlation coefficients computed.

The correlation coefficients were used to demonstrate the degree of the relationship between scores on the Eating Disorder Inventory and the Beck Depression Inventory. Chi square analysis was used to compare the proportion of African American college women with eating disorders to the proportion of white college women with the same disorders.

Discriminant analysis would have been used to ascertain which variables were related to membership in one of four groups: eating disorders only, depression only, eating disorders and depression, or no symptomatology.

Null Hypothesis

For each of the hypotheses presented, the null hypothesis stated the following:

1. African American female college students will not have eating disorders in the same proportion as white female college students.
2. Binge eating disorder is not the most common eating disorder in African American female college students.
3. There is no relationship between eating disorders and depression in African American female college students.
4. There is no relationship between womanist identity and the development of eating disorders or depression in African American female college students.

Data Analysis

Chi square analysis was used to compare the proportion of African American college women with eating disorders to the proportion of white college women with eating disorders. Correlational procedures were used to demonstrate the relationships between subscale scores on the Eating Disorder Inventory and the Beck Depression Inventory. Correlation coefficients were computed for the entire sample of participants and for participants at each institution.

Since no one took part in the qualitative portion of the study, no analysis was performed. This turn of events will be considered in depth in the final chapter.

Ethical Considerations

Guidelines regarding the use of human subjects were honored. Strict confidentiality was maintained of all information on study participants. However, having access to the actual names of participants was important in order to identify and refer any individual who had serious mental health or eating problems. It was suggested to all participants that if concerns or uncomfortable feelings arose as a result of the testing, they should seek help from the counseling center at their university. The informed consent statement is provided in Appendix A.

Critique

Potential threats to internal validity were addressed in the following manner:

History was not a factor in this study because no treatment occurred. Participants weren't likely to be affected by maturation since they were seen by the researcher only once, during the test administration. Since participants were not retested, potential threats from testing and statistical regression were eliminated. Using standardized instruments helped to address the issue of instrumentation. The brief time period involved reduced the probability of mortality. As there were no

control or treatment groups, no problems existed related to diffusion or imitation of treatment, compensatory rivalry, compensatory equalization of treatment, or resentful demoralization.

The most serious threat to the validity of this study was in regard to selection. Without randomization and with the use of intact groups, the possibility of bias increased. However, the potential for a larger sample size, which directly affected the integrity and ultimate generalizability of the study, outweighed the concerns of selection bias.

CHAPTER 4

ANALYSIS OF THE RESULTS

The purpose of this study was to investigate the relationship between eating disorders and depression in African American college women. The study also considered whether womanist identity served as a protective factor against one or both of these disorders.

The research findings will be presented in this chapter. The chapter is organized into four sections: description of the sample, descriptive statistics, data analysis specific to the research hypotheses, and qualitative analyses.

Description of the Sample

Information on the participants is provided for the entire sample and for participants at each institution. Participants were drawn from one predominantly white university (PWU) and one predominantly African American university (PAAU).

Seventy African American female college students took part in this study. All were undergraduates. Their ages ranged from 18 to 46. The mean age was 22.0, the median age 21.0, and the standard deviation 5.1 years. Their yearly family incomes ranged from \$5,000 to \$350,000, with a mean income of \$69,478, a median income of \$55,000, and a standard deviation of \$56,160. Table 1 presents the mean ages and incomes of all participants:

Table 1**Ages and Incomes of All Participants**

	Mean	Median	SD	N
Age	22.0	21.0	5.1	70
Income	\$69,478	\$55,000	\$56,160	69

Thirty-four African American female participants enrolled in a variety of programs were obtained from the predominantly white university (PWU). Their ages ranged from 18 to 21, with a mean age of 19.3, a median age of 19.0, and a standard deviation of .98 years. Yearly family incomes ranged from \$11,000 to \$200,000, with a mean family income of \$78,484, a median income of \$60,000, and a standard deviation of \$50,101.

Thirty-six African American female participants were obtained from the predominantly African American university (PAAU). All were nursing students. There was considerably more variation in this group. Participants' ages ranged from 20 to 46 with a mean age of 24.5, a median age of 22.5, and a standard deviation of 6.0 years. Yearly family incomes ranged from \$5,000 to \$350,000, with a mean family income of \$61,222, a median income of \$52,500, and a standard deviation of \$60,712. An independent samples t-test revealed significant differences between the groups with respect to age.

Table 2 provides a comparison of the ages and incomes of participants by university:

Table 2
Ages and Incomes of Participants from the PWU and

PAAU				
<u>PWU</u>				
	Mean	Median	SD	N
Age	19.3	19.0	.98	34
Income	\$78,484	\$60,000	\$50,101	33
<u>PAAU</u>				
	Mean	Median	SD	N
Age	24.5	22.5	6.0	36
Income	\$61,222	\$52,500	\$60,712	36

Descriptive Statistics

The following four instruments were administered to all participants: The Beck Depression Inventory-II (BDI), Eating Disorders Inventory-2 (EDI), Binge Scale, and the Womanist Identity Attitudes Scale (WIAS). Scores were analyzed for the entire sample of participants and by institution. The means and standard deviations for each instrument are reported in this section.

Scores for the Total Sample

Beck Depression Inventory (BDI)

According to this instrument, scores ranging from 14 to 19 are indicative of mild depression. A study by Beck et al. (1996) found that the mean score for college students was 12.6, and the standard deviation was 9.9. The researchers also reported that among outpatients, the mean score for those with no depression was 7.6, with a standard deviation of 5.9. Those who were mildly depressed had a mean score of 19.1, with a standard deviation of 5.7. Individuals who were moderately depressed had a mean score of 27.4, with a standard deviation of 10.0. Individuals with severe depression had a mean score of 32.9 and a standard deviation of 12.0.

In the present study of African American college women, the mean score for the total group was 7.7, with a standard deviation of 5.9, suggesting that most of these women do not suffer from depression. Table 3 shows the breakdown of scores by level of depression:

Table 3

BDI Scores for All Participants

Category	<i>f</i>	%
Not Depressed	61	88.4
Mild Depression	4	5.8
Moderate Depression	3	4.3
Severe Depression	1	1.4

Eating Disorder Inventory (EDI)

Scores on this instrument are reported for each subscale. The Drive for Thinness subscale is considered the primary indicator of eating problems. A score greater than 14 suggests weight preoccupation, which is associated with anorexia. Garner (1991) reported that for the normative group of nonpatient college women, a mean score of 5.5, and a standard deviation 4.4.

For the total sample of African American college women, the mean score on this subscale was 3.5, and the standard deviation, 5.0. These scores indicate that exaggerated concerns about dieting and weight are not issues for most women in this study. Nevertheless, there were variations among the women in this sample.

The Bulimia subscale measures thoughts about bingeing and actual bingeing behavior. The mean score in the normative group was 1.4, the standard deviation 2.8. Scores for the total sample in the present study averaged .81, with a standard deviation of 1.6. Although most participants scored low on this measure, 42% (n=30) reported that they ate when upset, 30% (n=21) responded affirmatively to the statement "I stuff myself with food," and 13% (n=9) reported thoughts about bingeing.

The Body Dissatisfaction subscale assesses the individual's unhappiness with the overall shape of the body and specific regions that tend to be of concern to persons with eating problems. In the normative group,

the mean score was 10.0, with a standard deviation of 7.6. In the total sample of African American college women, the mean was 8.6, and the standard deviation 7.4, suggesting that on the whole, these women were satisfied with their bodies.

The subscale on Ineffectiveness measures feelings of inadequacy and perceived lack of control over one's life. The mean for the normative group was 1.6, the standard deviation 3.2. Participants in the present study had a mean score of 1.7 and a standard deviation of 2.8.

Items on the Perfectionism subscale measure the extent to which an individual adheres to high standards of personal performance and believes that others expect the same of him or her. The mean score for the normative group was 6.5 and the standard deviation 4.3. African American women in the present study obtained a mean score of 7.4, with a standard deviation of 4.1.

The Interpersonal Distrust subscale assesses the respondent's feelings of alienation toward others and difficulties in forming close relationships. The normative group scored an average of 1.8, with a standard deviation of 2.6. Participants in the present study had a mean score of 2.7, and a standard deviation of 2.9.

The ability to recognize and appropriately respond to emotional states and physical sensations such as hunger and satiety is measured by the Introceptive Awareness subscale. The normative group had a mean of

3.0 and a standard deviation of 2.0. The participants in the present study had a mean of 1.9 and a standard deviation of 3.0.

The Maturity Fears subscale assesses the extent to which an individual wishes to retreat to the security of childhood. The mean for the normative group was 3.0 and the standard deviation was 2.0. African American women in the present study had a mean of 3.0 and a standard deviation of 2.9. The subscale scores for all participants on the Eating Disorder Inventory are reported in Table 4:

Table 4

EDI Scores for All Participants

Subscale	Mean	SD	N
Drive for Thinness	3.5	5.0	70
Bulimia	.81	1.6	70
Body Dissatisfaction	8.6	7.4	70
Ineffectiveness	1.7	2.8	70
Perfectionism	7.4	4.1	70
Interpersonal Distrust	2.7	2.9	70
Introceptive Awareness	1.9	3.0	70
Maturity Fears	3.0	2.9	70

Binge Scale

According to Pike et al. (1995), scores of 10 and below on this instrument are considered within the normal

range of eating patterns. Scores of between 11 and 14 are in the questionable range, and scores between 15 and 24 indicate an eating disorder. None of the participants in the present study scored above the normal range of eating behaviors. The mean for the entire sample of African American college women was 1.3, with a standard deviation of 2.4. Even so, 30% (n=21) of the participants admitted to at least occasional bingeing.

Womanist Identity Attitudes Scale (WIAS)

The four subscales of this instrument are Preencounter, Encounter, Immersion-Emersion, and Internalization. Scores are summed for each subscale, and the subscale with the highest score indicates the individual's predominant stage of womanist identity. With the exception of one participant, all the women were found to be at the highest stage of development, the Internalization stage, denoting a positive female identity. Table 5 presents the WIAS scores for the entire sample of participants:

Table 5

WIAS Scores for All Participants

Subscale	M	SD	N
Preencounter	2.0	.52	70
Encounter	3.0	.45	70
Immersion-Emersion	2.4	.42	70
Internalization	4.2	.37	70

Scores for the Predominantly White University (PWU)

Beck Depression Inventory (BDI)

For the BDI, the mean score for PWU participants was 9.4, with a standard deviation of 6.9, indicating that the majority of women in this sample were not clinically depressed. There were however, variations within the group, with 18% of the participants (n=6) exhibiting mild to severe depression. In addition, another 15% of the participants (n=5) had high scores, albeit in the subclinical range.

Since there appeared to be some disparity in the scores from the two institutions, t-tests for independent samples were performed. Significantly higher scores on this instrument were found in participants from the predominantly white university, compared to the predominantly African American university. In addition the variances were unequal. Table 6 presents the results of the t-test and the Levine's test for equality of variances ($p < .05$). Table 7 shows the number of participants in each depression category on the Beck Depression Inventory for the PWU and PAAU samples:

Table 6

Variance Between PWU and PAAU on the BDI

T-test for Independent Samples and Levine's Test					
	<i>t</i>	<i>df</i>	Sig.	F	Sig.
BDI	2.4	55.0	.02	4.5	.04

Table 7**BDI Scores for Participants from the PWU and PAAU**

Category	PWU		PAAU	
	<i>f</i>	%	<i>f</i>	%
Not Depressed	28	82.3	33	94.2
Mild	2	5.9	2	5.7
Moderate	2	5.9	0	
Severe	1	2.9	0	

Eating Disorder Inventory (EDI)

Scores for participants at the PWU were higher than those for the PAAU. While no significant differences were found between the groups on this instrument, unequal variances were discovered on the Interpersonal Distrust and Introceptive Awareness subscales, indicating more variability in the PAAU sample.

Seventeen percent (n=3) of the participants from the PWU had scores above 14 on the Drive for Thinness subscale. These elevated scores suggest weight preoccupation. In a treatment setting, clinical interviews would be appropriate with these individuals to determine whether a bona fide eating disorder exists (Garner, 1991).

Furthermore, on the Bulimia subscale, a full 50% (n=17) of the participants at the PWU reported that at least "sometimes" they ate when upset. Twenty-nine percent (n=10) of these women responded affirmatively to the

statement "I stuff myself with food." Fifteen per cent (n=5) stated that they thought about bingeing, and 12% (n=4) reported they had thoughts about vomiting in order to lose weight. Eight per cent (n=3) of the PWU participants admitted to going on eating binges where they felt they couldn't stop, and another 8% (n=3) reported eating moderately in front of others but bingeing when they were alone. In Table 8 the scores from the predominantly white and predominantly African American universities are compared on the Eating Disorder Inventory. T-test results are also shown:

Table 8

EDI Scores for Participants from the PWU and PAAU

Subscale	PWU (n=34)		PAAU (n=36)			
	M	SD	M	SD	t	Sig.
Drive for Thinness	3.1	5.3	3.9	4.7	-.64	.52
Bulimia	.94	1.9	.69	1.3	.62	.53
Body Dissatisfac.	7.7	6.5	9.4	8.1	-.97	.34
Ineffectiveness	1.9	2.9	1.6	2.8	.48	.63
Perfectionism	8.0	3.7	6.9	4.4	1.1	.27
Interpersonal	3.0	3.4	2.4	2.2	.92	.35
Introceptive	2.5	3.4	1.3	2.5	1.7	1.0
Maturity Fears	3.3	3.3	2.7	2.4	.70	.48

Binge Scale

The mean score for the predominantly white

university was 1.9, and the standard deviation 2.8. No participants tested above the normal range, and none reported bingeing and purging, but 22% (n=8) reported at least occasional binge eating.

Womanist Identity Attitudes Scale (WIAS)

Thirty-three of the thirty-four participants at the PWU scored at the Internalization stage of development, indicating that this stage was their predominant mode of operation. The lone individual whose highest subscale score indicated a lower stage of development was found to be in the Immersion-Emersion stage, the next highest level of womanist identity. Table 9 shows the mean scores on the WIAS for the predominantly white and predominantly African American universities:

Table 9

WIAS Scores for Participants from the PWU and PAAU

Subscale	PWU			PAAU		
	M	SD	N	M	SD	N
Preencounter	2.1	.46	34	2.1	.47	36
Encounter	3.1	.49	34	2.9	.40	36
Immersion-Emersion	2.5	.45	34	2.3	.37	36
Internalization	4.2	.32	34	4.1	.42	36

Scores for the Predominantly African American University
(PAAU)

Beck Depression Inventory (BDI)

The group mean at the PAAU was 6.0, with a standard deviation of 4.3, indicating that the majority of women in this sample were not depressed. Only 5% (n=2) of the women scored in the mild range, and none scored in the moderate or severe range. An additional 5% (n=2) had high scores in the subclinical range. Scores for the sample at the PAAU were lower than the scores for the sample at the PWU, and the difference in the group means was statistically significant.

Eating Disorders Inventory (EDI)

Scores for participants from the PAAU on this instrument tended to be lower than the scores from the PWU and the total group. Mean differences were not statistically significant but the variances were unequal for the Interpersonal Distrust and Introceptive Awareness subscales.

Eighteen percent of individuals (n=2) had scores over 14 on the Drive for Thinness subscale. These elevated scores indicate weight preoccupation.

On the Bulimia subscale, 36% (n=13) of the participants from the PAAU reported that they ate when upset, 30% (n=11) responded affirmatively to the statement "I stuff myself with food," and 11% (n=4) stated that they thought about bingeing. Only 5% of the PAAU participants reported thinking about vomiting in order to lose weight, 2% (n=1) admitted to going on eating binges and not being able to stop, and 2% (n=1)

reported eating moderately in front of others and bingeing in private.

Binge Scale

The mean for the PAAU group was .72, and the standard deviation, 1.7. No participants in this sample were found to have binge eating disorder, no participants admitted to bingeing and purging, but 22% (n=8) reported at least occasional binge eating.

Womanist Identity Attitudes Scale (WIAS)

All thirty-six participants in the PAAU sample scored at the Internalization stage of womanist identity development. This is considered the highest stage of development and suggests that these participants have positive views of themselves as women.

Data Analysis for Research Hypotheses

Hypothesis 1

African American female college students will have eating disorders in the same proportion as white female college students.

This hypothesis was tested by computing a chi square test of independence. Scores for participants in the present study were compared to scores in study by Gray and Ford (1985) investigating bulimia in a sample of white female college students. Tables 10 and 11 show the chi square analyses. Group 1 represents the study by Gray and Ford (1985) and Group 2 represents the present study by this researcher. The responses indicate either

the presence of an eating disorder (ED), in this case bulimia, or the absence of an eating disorder (NED):

Table 10

Group * Response Crosstabulation

		<u>Response</u>		
		ED	NED	Total
<u>Group 1</u>	Count	28	192	220
(Gray & Ford)	% within Group	13%	88%	100%
	% within Response	100%	73%	76%
<u>Group 2</u>	Count		70	70
(Ford)	% within Group		100%	100%
	% within Response		27%	24%
<u>Total</u>	Count	28	262	290
	% within Group	10%	90%	100%
	% within Response	100%	100%	100%

Table 11

Chi Square Test

	Value	df	Sig.
Pearson Chi Square	9.98	1	.002

Chi square analysis revealed that a significantly greater proportion of white college women had eating disorders than African American college women. No participants in this study had bulimia. Although other studies have found that a significant proportion of white

female college students have eating disorders (Fredenberg et al., 1996; Gray & Ford, 1985; Minz & Betz, 1998; Schwitzer et al., 1998) it was not confirmed in this study that African American female college students had eating disorders, therefore, this hypothesis was not supported.

Hypothesis 2

Binge eating disorder will be the most common eating disorder in African American female college students.

This hypothesis was not supported. No participants in this study were found to have binge eating disorder. There are several possible reasons for this finding, which will be discussed in the following chapter.

Hypothesis 3

There is a positive relationship between the level of depression and the existence of eating disorders in African American female college students.

This hypothesis was tested by computing Pearson correlation coefficients to assess the strength and direction of the relationship between subscale scores on the Eating Disorder Inventory (EDI) and the scores on the Beck Depression Inventory (BDI). Correlation coefficients were computed for the entire sample of participants at both institutions, and separately for participants at each institution.

With respect to the entire sample, the data revealed significant positive correlations for the Drive for

Thinness, Bulimia, Ineffectiveness, Perfectionism, Introceptive Awareness, and Maturity Fears subscales on the EDI and the BDI. Most correlations were in the moderate to weak range, with the highest occurring between the Bulimia (.57), Maturity Fears (.56), and Ineffectiveness (.54) subscales of the EDI and the BDI. Table 12 presents the correlation coefficients for the entire sample of participants:

Table 12
Correlations Between the EDI and BDI for the Entire
Sample

Subscale	1	2	3	4	5	6	7	8	9
	(n = 69)								
1. BDI	--	.29*	.57*	.13	.54*	.30*	.13	.49*	.56*
2. EDI DT			.34*	.76*	.40*	.37*	.08	.43*	.30*
3. EDI Bulimia				.27*	.40*	.18	.03	.44*	.43*
4. EDI Body Dis.					.29*	.20	.04	.34*	.20
5. EDI Ineffec.						.25*	.25*	.56*	.50*
6. EDI Perfec.							.16	.43*	.23
7. EDI Interper.								.34*	.25*
8. EDI Introcep.									.51*
9. EDI Maturity									

*Correlation is significant at the 0.05 level (2-tailed).

In the sample of participants from the predominantly

white institution, strong to moderate correlations were discovered between many of the subscales on the EDI and the BDI. The strongest correlations existed between the Ineffectiveness (.73) and Bulimia (.71) subscales of EDI and the BDI. Table 13 presents the correlation coefficients for the eating disorder and depression instruments from participants at the predominantly white university:

Table 13

Correlations Between the EDI and BDI for the PWU

Subscale	1	2	3	4	5	6	7	8	9
(n = 34)									
1. BDI	--	.37*	.71*	.73*	.29	.26	.08	.58*	.58*
2. EDI DT			.38*	.54*	.81*	.33	.07	.47*	.30
3. EDI Bulimia				.50*	.30	.26	-.12	.35*	.43*
4. EDI Ineffec.					.43	.19	.33	.65*	.42*
5. EDI Body Dis.						.26	.06	.31	.21
6. EDI Perfec.							.18	.43*	.17
7. EDI Interper.								.39*	.16
8. EDI Introcep.									.55*
9. EDI Maturity									

*Correlation is significant at the 0.05 level (2-tailed).

One moderate correlation was observed in the scores at the predominantly African American university. The

only significant correlation was found between the Maturity Fears (.50) subscale of the EDI and the BDI. Table 14 presents the results from the predominantly African American university:

Table 14

Correlations Between the EDI and BDI for the PAAU

Subscale	1	2	3	4	5	6	7	8	9
(n = 35)									
1. BDI	--	.20	.26	.34	.20	.28	.18	.17	.50*
2. EDI DT			.32	.74*	.28	.44*	.13	.57*	.31
3. EDI Bulimia				.29	.27	.08	.12	.60*	.42*
4. EDI Body Dis.					.20	.19	.07	.46*	.24
5. EDI Ineffec.						.29	.13	.45*	.62*
6. EDI Perfec.							.10	.42*	.30
7. EDI Interper.								.20	.40*
8. EDI Introcep.									.42*
9. EDI Maturity									

*Correlation is significant at the 0.05 level (2-tailed).

Based on the statistical analyses, this hypothesis was confirmed for the entire sample and the PWU. It was not, however confirmed for the PAAU.

Hypothesis 4

There is a relationship between womanist identity and the development of eating disorders or depression in African American female college students.

This hypothesis could not be tested because there was no variance in the sample on the Womanist Identity Attitudes Scale. All of the participants, with the exception of one, scored at the highest level of womanist identity development on the WIAS, indicating they were operating at the Internalization stage of development. In addition, when subscale scores of the WIAS were correlated with the Beck Depression Inventory, and the Bulimia and Drive for Thinness subscales of the Eating Disorder Inventory, few significant correlations were discovered between the WIAS and the depression and eating disorder instruments, suggesting there is little relationship between scores on the WIAS and scores on the BDI or EDI.

Qualitative Analyses

The researcher had planned to utilize a phenomenological perspective and interview participants whose scores on the Eating Disorder Inventory indicated the existence of eating problems. However, no participants were found with full-fledged eating disorders. Even so, there were individuals whose scores suggested weight preoccupation or problems with body image. When the researcher approached these individuals, the participants responded by stating that they did not believe they had any difficulties, therefore, did not wish to be interviewed. Possible reasons for the lack of cooperation will be discussed in chapter 5.

Summary

This chapter presented the research findings. Four hypotheses were tested in this study. One of the four hypotheses was supported.

It was not confirmed that African American college women in this sample had eating disorders, and binge eating disorder was not the most common eating problem affecting African American female college students in this sample. Although no participants were found with full-fledged eating disorders, there was some evidence of disturbed eating patterns, particularly among the participants in the predominantly white university.

A significant, positive relationship was discovered between depression and eating problems among the women in this study. Strong correlations on the EDI and BDI were found in the participants from the predominantly white institution.

The influence of womanist identity on eating disorders and/or depression could not be ascertained because almost all of the participants tested at the highest stage of womanist identity development. Without variance, it is impossible to determine relationships.

In the next chapter the implications of the findings, conclusions, and limitations of the study will be discussed. Finally, recommendations for further research will be made.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

This study examined the relationships among eating disorders, depression, and womanist identity in a sample of African American female college students at one predominantly white and one predominantly African American institution. An African American feminist perspective was employed in conceptualizing these phenomena and considering whether stressors such as racial, gender, and economic pressures contribute to the development of eating disorders and/or depression. A positive female identity was also examined as a possible protective factor.

This chapter is divided into five sections: an examination of the hypotheses, the qualitative discussion, limitations, implications, and suggestions for future research.

Examination of Hypotheses

Hypothesis 1

The first hypothesis stated that the African American female college students would have eating disorders in the same proportion as white female students. This hypothesis was not supported. Although there was evidence of disturbances in eating patterns and

body image among some participants, no African American women in this study were conclusively identified with eating disorders, whereas other studies (Fredenberg et al., 1996; Minz & Betz, 1988; Schwitzer et al., 1998) found eating disorders to be a serious problem in the white female college population. Gray et al. (1987) and Abrams et al. (1993) found significantly lower instances of eating disorders in African American college women, compared to white college women. Even so, Gray et al. found evidence of bulimia in African American women. Lester and Petrie (1998) compared scores on an assessment to detect bulimia in African American and white female college students and found no significant differences between the groups.

The hypothesis of similar rates of eating disorders in African American and white college women was advanced because few previous studies on this population considered binge eating disorder. However, the use of an instrument to detect binge eating did not aid in identifying additional women with eating disorders.

Nevertheless, it must be noted that subclinical scores on the instruments did not preclude the existence of problems. Despite the lack of bona fide disorders, there was a substantial percentage of women who reported

unhealthy eating patterns, including eating when upset (42%), "stuffing themselves with food" (30%), and thinking about bingeing or purging (21%). Even if their eating behaviors are somewhat controlled, the use and abuse of food among this sample is of great concern and warrants further investigation.

Hypothesis 2

The second hypothesis was that binge eating disorder would be the most common eating disorder in study participants. That hypothesis was also not confirmed. There are several possible explanations for this outcome. It is possible that participants from each university were not entirely reflective of the population at that institution, as the participants at the predominantly white university were women who were highly involved in campus activities, and only nursing students participated at the predominantly African American university. The lack of representativeness of each population in the study may have skewed the results.

It is also possible that binge eating is simply not an issue for women in this study, but the responses to specific questions on the eating disorder instruments cast aspersions on this explanation. Again, 42% of the total group of participants admitted to eating when

upset, an even higher percentage of 50% was reported in the PWU sample. Thirty percent of all participants acknowledged "stuffing themselves with food" and 30% of the participants reported bingeing at least occasionally. In addition, 6% of the total sample admitted to going on binges and being unable to stop eating, and another 6% reported eating moderately in front of others and overeating in private. Clearly, bingeing is a behavior in which many of these women engage, often in response to stress. Gray et al. (1987) also found high rates of bingeing in African American college women. Seventy-one per cent of the African American women in their study reported binge eating.

The utility of the instruments to assess binge eating must be considered. The Eating Disorder Inventory, while offering useful information regarding eating patterns, was not designed to measure binge eating disorder. The Binge Scale targets bingeing behavior but is rather transparent in that the respondent is acutely aware of the behavior being assessed, which may influence his or her answers. One wonders if another instrument may be more suitable to assess this disorder.

Hypothesis 3

The third hypothesis stated that there was a

positive relationship between the level of depression and the existence of eating disorders in African American female college students. This hypothesis was based on research that found a definite link between the two disorders (Grubb et al., 1993; Marcus et al., 1990; Willcox and Sattler, 1996).

Although no women in the present study were found with full-fledged eating disorders, a significant, positive relationship was demonstrated between level of depression and existence of eating problems. There were particularly strong correlations between some of the subscales on the Eating Disorder Inventory and the Beck Depression Inventory in the sample from the predominantly white university. The correlations were as high as .71 for the Bulimia subscale of the EDI, which examines eating patterns, and .73 for the Ineffectiveness subscale of the EDI, which assesses perceptions of adequacy and control over one's life. The significant correlations offer evidence that the behaviors are related.

In further examining the Bulimia and Ineffectiveness subscales of the EDI, and the BDI scores at the predominantly white university, it is possible to relate the constructs being assessed to the African American feminist theoretical framework being utilized in this

study. It is also relevant to cite the work of other researchers.

Participants from the predominantly white university had significantly higher scores on the depression inventory, compared to participants from the predominantly African American university. Also, in the sample of women from the PWU, strong associations were found between feelings of inadequacy and lack of control over one's life, demonstrated by the Ineffectiveness subscale on the EDI, and feelings of depression, demonstrated by the BDI. In addition, there were equally strong associations between the unhealthy eating behaviors measured by the Bulimia subscales of the EDI, and depression scores on the BDI. While it is impossible to determine causality, it is reasonable to speculate about the findings in the PWU sample. Perhaps a more hostile and unsupportive environment, such as is often found at predominantly white universities, exacerbates feelings of inadequacy and perceived lack of control, depression, or unhealthy eating patterns that may already be present in some African American women at predominantly white institutions. The environment may be interacting with one area of vulnerability, such as a tendency toward depression, and promoting the development

of another problem, such as unhealthy eating patterns. There could also be a confluence between the eating behaviors, feelings of inadequacy and powerless, and feelings of depression so that each problem influences the other.

Other researchers (D'Augelli & Hershberger, 1993; Fleming, 1983, 1984; Smedley et al., 1993) have documented the challenges that African American women face at predominantly white universities. These challenges encompass issues of race, gender, and economics (D'Augelli & Hershberger, 1993; Fleming, 1983, 1984; Launier, 1997; Smedley et al., 1993.)

It has already been noted that racial, gender, economic inequalities play a significant role in the development of eating disorders and depression, either singly or in combination (Barbee, 1992; McGrath et al. 1990; Mitchell & Herring, 1998; Thompson, 1992, 1994a, 1994b). Although the specific pressures encountered by African American college women at predominantly white universities are in some respects unique, the overall challenge of contending with race, gender, and economics may be similar to the problems faced by African American women in the general society.

An alternative explanation for the differences in

the scores between the PWU and PAAU samples on the Eating Disorder Inventory and the Beck Depression Inventory might be related to the career choice of the women at the predominantly African American institution. As future nurses, they may have had greater awareness of and access to information on health and wellness. However, their increased knowledge may have also resulted in the nursing students being more savvy in completing the assessments and knowing the "right" answers, even if they were not practicing healthy behaviors.

Another possibility is that differences in the scores may be a function of age. It was already established that the participants at the predominantly African American university were significantly older. Perhaps the women at the PAAU had better coping skills and were more resilient due to maturity and/or a wider range of life experiences.

A final explanation may be that the disparity in the BDI scores at the PWU and PAAU may not be attributable to any one factor. Differences could be due to a combination of all the possibilities mentioned above.

Hypothesis 4

The fourth hypothesis stated that there was a relationship between womanist identity and the

development of eating disorders and/or depression in African American college women. This hypothesis could not be tested due to the lack of variance in the sample. Of the 70 women in the study, it was found that 69 operated at the Internalization stage as their predominant mode. The Internalization stage is considered the highest stage of womanist identity development.

African American college women in this study had positive concepts of womanhood. The uniformly high scores on the Internalization subscale of the WIAS are consistent with the findings of other researchers. Gibbs & Fuery (1998) noted high self-esteem among African American women, and positive feelings about oneself may extend to one's gender. And as mentioned previously, high internalization scores on the WIAS are correlated with high self-esteem and psychological well-being (Ossana et al., 1992; Poindexter-Cameron & Robinson, 1997).

It may also be relevant that in many African American communities attending college is considered a privilege not available to everyone due to economic and other barriers. Statistics confirm that college enrollment of African Americans is proportionally lower

than white enrollment (Schroeder, 1997). Perhaps positive self-regard and confidence are necessary to be among the "chosen few."

Another explanation is that there may actually be variations in female identity development among these participants which were not detected by the instrument used. Some alternative measure may need to be identified or developed in order to adequately assess this population.

In summary, although only one of the hypotheses was confirmed, there are a number of indicators of problematic eating behaviors among women in this study, even if they fall below clinical diagnosis or statistical significance. That there was more evidence of eating problems and depression in the sample from the predominantly white university may be indicative of increased pressures in that environment. Alternatively, differences may also be due to inherent differences in the two samples, or even some combination of these explanations.

The participants in this study have positive views of themselves as women, which may be reflective of the high self-esteem many African American women hold, or may be related to their relatively privileged status,

compared to poor and working class African Americans. Problems in the construction of the womanist assessment instrument may have also influenced the uniformity of the scores.

Qualitative Discussion

Qualitative interviews were planned as a part of this study. The researcher intended to talk with approximately three to five participants about the experience of binge eating disorder. As no participants were discovered with this disorder or any full-fledged eating disorder, attempts were made to interview participants whose scores on the Eating Disorder Inventory suggested problems with eating behaviors or body disturbance, such as the individuals with elevated scores on the Drive for Thinness or Body Dissatisfaction subscales. That the researcher was uniformly rebuffed in her request for interviews merits some consideration.

Since the participants who were approached for interviews were adamant that they did not have eating or body image problems, they were not interested in being interviewed. There may have been a genuine lack of understanding on the part of these women regarding healthy versus unhealthy eating patterns and body image.

Denial on the part of participants is another

possibility. Some individuals may not have been open to hearing possibly disturbing information. Keeping one's defenses in tact may be one way of coping in a difficult environment.

There is also a cultural factor which must be acknowledged. For many African Americans it is considered taboo to discuss personal information with strangers, even of one's own race.

In retrospect it may only be reasonable to expect individuals to talk about their experiences if they have already self-identified as having eating problems. The other possibility would be to have participants engaged in a counseling intervention in which they have an opportunity to explore their eating patterns and experiences, and also develop a greater degree of comfort with and trust in the investigator.

Limitations

The most significant limitation of this study related to the sample. Participants from the predominantly white university were women enrolled in a variety of academic programs who belonged to multiple campus organizations. Participants from the predominantly African American university were all nursing students and were significantly older than the

PWU sample. There were other demographic differences between the groups that are not fully known, such as marital status, parents versus nonparents, and self-support versus financial dependency. These two groups may have been different from the outset and those inherent differences may have confounded the results.

Moreover, in both universities, the accessible population may not have been representative of the total population of African American undergraduate women at each institution. Thus, questions are raised regarding the generalizability of the results.

A related issue is that participants in this study attend universities that are well regarded and extremely selective. African American women attending these exclusive schools may be different from those who attend less exclusive universities. Again, the generalizability of the results must be considered.

Another limitation was the use of self-report instruments. These instruments, while extremely valuable and widely used, do provide opportunities for respondents to under or over-report symptoms and attempt to answer questions in a way they believe will create a favorable impression of themselves or please the researcher.

A final limitation was the use of volunteers. For

ethical and practical reasons, participants were required to provide informed consent before taking part in this research study. However, there are marked differences between individuals who volunteer for any activity and those who do not. This limitation is almost impossible to avoid.

Implications

More investigation is needed on eating disorders and depression in African American female college students, since it was previously established that subclinical scores on assessment measures do not eliminate the possibility of unhealthy eating behaviors. Given the high correlation between eating disorders and depression, clinicians should be aware of potential eating problems in clients who present with moderate or severe depression. Conversely, individuals who present with eating problems should be screened for depression.

Attention must also be given to the assessment instruments for eating disorders and female identity currently available. As the instruments in this study may not have fully captured the disturbed eating patterns and variations in gender identity for this sample, more sensitive instruments that are appropriate for African American college women may need to be identified or

developed. In addition, it may be advisable to supplement the use of eating disorder instruments with clinical interviews in order to better identify and understand problematic behaviors.

Due to the many challenges that African American women face, counselors, faculty, and administrators who work with African American female students must be sensitive to their needs and insure that students feel supported and that help is readily available for eating problems, mood disorders, or other difficulties that African American women may encounter.

Suggestions for Future Research

There are a number of areas relating to African American female college students, eating disorders, and depression that warrant further consideration. It may be helpful to replicate aspects of this study with other African American college women. Since individuals completing the Binge Scale may be aware of the behaviors being assessed and alter their answers, another instrument to measure binge eating, such as the Questionnaire on Eating and Weight Patterns, could be administered along with the Beck Depression Inventory and the Eating Disorders Inventory to see if the results would differ. Use of a clinical interview along with the

eating disorder and depression instruments might offer additional information. Due to the limitations already noted in regards to the sample in this study, repeating the study with a more representative sample of African American college women might prove beneficial.

Studies utilizing qualitative methodology could provide especially rich information on maladaptive eating patterns. However, participants would have to already have acknowledged problems with their eating in order to eliminate or reduce resistance.

This study surveyed behaviors and attitudes regarding eating disorders and depression, which represented an important first step. An intervention to examine the most effective treatment strategies for eating disordered and/or depressed African American women would be of tremendous value and a logical next step. Interventions that integrate cultural influences such as spirituality might be particularly powerful.

The present study focused solely on African American college women. Future studies comparing the responses of African American female college students and African American women in the general population may offer insight into the differences and similarities between the groups. In addition, a large-scale study on the eating

patterns and mental health status of African American women in the larger society is critically needed in order to fully understand and address their unique treatment needs.

Finally, to make any substantial and lasting changes in the negative eating behaviors and affective states of African American women, attention must be given to external influences that can either aid or hinder development. In order for African American women to truly achieve optimal health, efforts must be made to strengthen African American families and communities, and ultimately, to change inequities in our society.

Appendix A
Informed Consent Statement

**African American Female College Students Research Study
Informed Consent Statement**

Thank you for agreeing to participate in this research project. The purpose of the study is to learn more about African American female college students and issues that may assist or prohibit their progress in school and in other areas of their lives. This is a one time only activity unless you agree to be interviewed at a later date.

It is not expected that any of the questions asked will cause undue discomfort, however, if any uncomfortable feelings arise and you need to talk to someone, you are encouraged to contact the College's Counseling Center. If you have any questions or need more information, you may contact the researcher, Theresa Ford, at txford@wm.edu.

Your participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty.

All records will be held in strict confidence. Only the researcher will have access to the names of participants.

The information obtained in this study will expand our knowledge regarding pertinent issues for African American female students. The results may also help staff and faculty to work better with diverse students.

I have read the previous statement and agree to participate in this research study. I am at least 18 years of age.

Name (print) _____ Date _____

Signature _____

Appendix B
Demographic Information Sheet

African American Female Student SurveyDemographic Information

Thank you for agreeing to participate in this research study. The information you provide is very important and will be held in the strictest confidence.

Name _____ Date _____

Age _____ Yearly Family Income _____

Appendix C
Binge Scale

Name _____

Date _____

Binge Scale Questionnaire

1. How often do you binge eat?
 - a. Never
 - b. Seldom
 - c. Once or twice a month
 - d. Once a week
 - e. Almost every day

2. What is the average length of a binge eating episode?
 - a. Less than 15 minutes
 - b. 15 minutes to one hour
 - c. One hour to four hours
 - d. More than four hours

3. Which of the following statements best applies to your binge eating?
 - a. I eat until I have enough to satisfy me
 - b. I eat until my stomach feel full
 - c. I eat until me stomach is painfully full
 - d. I eat until I can't eat any more

4. Do you ever vomit after a binge?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

5. Which of the following best applies to your eating behavior when binge eating?
 - a. I never binge eat
 - b. I eat more slowly than usual
 - c. I eat about the same as I usually do
 - d. I eat very rapidly

6. How much are you concerned about your binge eating?
 - a. Not bothered at all
 - b. Bothers me a little
 - c. Moderately concerned
 - d. A major concern

7. Which best describes your feelings during a binge?
 - a. I never binge
 - b. I feel that I could control the eating if I chose
 - c. I feel that I have at least some control
 - d. I feel completely out of control

Binge Scale, Page 2**Name** _____

8. Which of the following describes your feelings after a binge?
- a. I never binge
 - b. I feel fairly neutral, not too concerned
 - c. I am moderately upset
 - d. I hate myself
9. Which most accurately describes your feeling after a binge?
- a. I never binge
 - b. Not depressed at all
 - c. Mildly depressed
 - d. Moderately depressed
 - e. Very depressed

Appendix D
Womanist Identity Attitudes Scale

Social Attitudes Inventory (Form W)

Instructions: This questionnaire is designed to measure people's attitudes about social and political issues. There are no right or wrong answers. Different people have different viewpoints. So, try to be as honest as you can. Besides each statement, circle the number that best describes how you feel. Use the scale below to respond to each statement.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

(circle here)

1 2 3 4 5	1.	In general, I believe that men are superior to women.
1 2 3 4 5	2.	I think women blame men too much for their problems.
1 2 3 4 5	3.	I believe that being a woman has caused me to have many strengths.
1 2 3 4 5	4.	Women should not blame men for all of women's social problems.
1 2 3 4 5	5.	I do not know whether being a woman is positive or negative.
1 2 3 4 5	6.	I feel more comfortable being around men than I do being around women.
1 2 3 4 5	7.	I feel unable to involve myself in men's experiences, and I am increasing my involvement in experiences involving women.
1 2 3 4 5	8.	I am comfortable wherever I am.
1 2 3 4 5	9.	Maybe I can learn something from women.
1 2 3 4 5	10.	Sometimes I think men are superior and sometimes I think they are inferior to women.
1 2 3 4 5	11.	In general, women have not contributed much to American society.
1 2 3 4 5	12.	When I think about how men have treated women, I feel an overwhelming anger.
1 2 3 4 5	13.	People, regardless of their sex, have strengths and limitations.
1 2 3 4 5	14.	Sometimes I am proud of belonging to the female sex and sometimes I am ashamed of it.
1 2 3 4 5	15.	S ometimes, I wish I had been born a man.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

1 2 3 4 5	16.	I am determined to find out more about the female sex.
1 2 3 4 5	17.	Being a member of the female sex is a source of pride to me.
1 2 3 4 5	18.	Thinking about my values and beliefs takes up a lot of my time.
1 2 3 4 5	19.	I do not think I should feel positively about people just because they belong to the same sexual group as I do.
1 2 3 4 5	20.	I would have accomplished more in this life if I had been born a man.
1 2 3 4 5	21.	Most men are insensitive.
1 2 3 4 5	22.	Women and men have much to learn from each other.
1 2 3 4 5	23.	I am not sure how I feel about myself.
1 2 3 4 5	24.	Sometimes I wonder how much of myself I should give up for the sake of helping other minorities.
1 2 3 4 5	25.	Men are more attractive than women.
1 2 3 4 5	26.	I reject all male values.
1 2 3 4 5	27.	Men have some customs that I enjoy.
1 2 3 4 5	28.	Men are difficult to understand.
1 2 3 4 5	29.	I wonder if I should feel kinship with all minority group people.
1 2 3 4 5	30.	Women should learn to think and act like men.
1 2 3 4 5	31.	My most important goal in life is to fight the oppression of women.
1 2 3 4 5	32.	I enjoy being around people regardless of their sex.
1 2 3 4 5	33.	I feel myself replacing old friends with new ones who share my beliefs about women.
1 2 3 4 5	34.	The burden of living up to society's expectations of women is sometimes than I can bear.
1 2 3 4 5	35.	I limit myself to male activities.
1 2 3 4 5	36.	Both sexual groups have some good people and some bad people.
1 2 3 4 5	37.	I feel anxious about some of the things I feel about women.
1 2 3 4 5	38.	I feel like I am betraying my sex when I take advantage of the opportunities available to me in the male world.
1 2 3 4 5	39.	I want to know more about the female culture.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

1 2 3 4 5	40.	I think women and men differ from each other in some ways, but neither group is superior.
1 2 3 4 5	41.	I find that I function better when I am able to view men as individuals.
1 2 3 4 5	42.	I limit myself to activities involving women.
1 2 3 4 5	43.	Most men are untrustworthy.
1 2 3 4 5	44.	American society would be better off if it were based on the cultural values of women.

Appendix E
Qualitative Questionnaire

Qualitative Interview Questionnaire

1. When did you become aware of having eating problems? How did you learn about it?
2. What were your feeling when you realized that this was a problem for you?
3. Describe your experience of binge eating.
 - a. First, tell me what it looks like. For example, if I had a video camera and recorded you, what would I see?
 - b. Now describe what it feels like.
4. What, if anything, triggers an episode?
5. What helps you to stop or feel better?
6. Have you ever sought professional help for this problem?
7. How does this issue affect your ability to live your life?
8. How has this issue affected your school experience?
9. Is your status as an African American female student at this institution related to your problems with eating? For example, has the eating problem started, stopped, gotten worse or better since you've been here?
10. What, if anything, can you do about your eating problem?

REFERENCES

- Abrams, K.K., Allen, L., & Gray, J.J. (1993). Disordered eating attitudes and behaviors, psychological adjustment, and ethnic identity: A comparison of black and white female college students. International Journal of Eating Disorders, 14, 49-57.
- Akan, G.E., & Grilo, C.M. (1995). Sociocultural influences on eating attitudes and behaviors, body image and psychological functioning: A comparison of African-American, Asian American and Caucasian college women. International Journal of Eating Disorders, 18, 181-187.
- Allen, W.R., & Strong, B.M. (1996). National study of Black college students. In R.L. Jones (Ed.), Handbook of tests and measurements for Black populations, Volume 1. Hampton, VA: Cobb & Henry Publishers.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.
- Ancis, J.R., Sedlacek, W.E., & Mohr, J.J. (2000). Student perceptions of campus climate by race. Journal of Counseling and Development, 78, 180-186.
- Anderson, A.E., & Hay, A. (1985). Racial and socioeconomic influences in anorexia and bulimia. International Journal of Eating Disorders, 4, 479-487.
- Barbee, E.L. (1992). African American women and depression: A review and critique of the literature. Archives of Psychiatric Nursing, 6, 257-265.

Beck, A.T., Steer, R.A., & Brow, G.K. (1996). Beck depression inventory manual (2nd ed.). San Antonio: The Psychological Corporation.

Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review, 8, 77-100.

Brown, D.R., Ahmed, F., Gary, L.E., & Milburn, N.G. (1995). Major depression in a community sample of African Americans. American Journal of Psychiatry, 152, 373-378.

Cabrera, A.F., Nora, A., Terenzini, P.T., Pascarella, E., & Hagedorn, L.S. (1998). Campus racial climate and adjustment of students to college: A comparison between white students and African American students. Journal of Higher Education, 70, 134-136.

Carr, J.G., Gilroy, F.D., & Sherman, M.F. (1996). Silencing the self and depression in women: The moderating role of race. Psychology of Women Quarterly, 20, 375-292.

Carter, R.T., & Parks, E.E. (1996). Womanist identity and mental health. Journal of Counseling and Development, 74, 484-489.

Cochran, S.D., & Mays, V.M. (1994). Depressive distress among homosexually active African American men and women. American Journal of Psychiatry, 151, 524-529.

Collins, P.H. (1991). Black feminist thought: Knowledge, consciousness and the politics of empowerment. New York: Routledge Press.

Combahee River Collective. (1995). A black feminist statement. In B. Guy-Sheftall (Ed.), Words of fire: An anthology of African-American feminist thought (pp. 232-240). New York: The New Press.

Creswell, J.W. (1994). Research design: Qualitative and quantitative approaches. Thousand Oaks, CA: Sage Publications.

Creswell, J.W. (1998). Qualitative inquiry and research design: Choosing among the five traditions. Thousand Oaks, CA: Sage Publications.

Cross, W.E. (1971). Negro-to-Black conversion experience: Toward a new psychology of Black liberation. Black World, 20, 13-27.

Crosson, P.H. (1992). Environmental influences on minority degree attainment. Equity and Excellence, 25, 5-16.

Crute, S. (Ed.). (1997). Health and healing for African-Americans. Emmaus, PA: Rodale Press.

Danquah, M.N.A. (1998). Willow weep for me: A Black woman's journey through depression. New York: W.W. Norton & Company.

D'Augelli, A.R., & Hershberger, S.L. (1993). African American undergraduates on a predominantly white campus:

Academic factors, social networks, and campus climate. Journal of Negro Education, 62, 67-81.

Davis, A. (1981). Women, race and class. New York: Vintage Books.

Davis, R.E. (1997). Trauma and addiction experiences of African American women. Western Journal of Nursing Research, 19, 442-466.

Devlin, M.J., Walsh, B.T., Spitzer, R.L., & Hasin, D. (1992). Is there another binge eating disorder? A review of the literature on overeating in the absence of bulimia nervosa. International Journal of Eating Disorders, 11, 333-340.

de Zwaan, M., Mitchell, J.E., Seim, H.C., Specker, S.M., Pyle, R.L., Raymond, N.C., & Crosby, R.B. (1994). Eating related and general psychopathology in obese females with binge eating disorder. International Journal of Eating Disorders, 15, 43-52.

Dismore, B.D., & Mallinckrodt, B. (1996). Emotional self-awareness, eating disorders, and racial identity attitudes in African American women. Journal of Multicultural Counseling and Development, 24, 267-277.

Downing, N.E., & Roush, K.L. (1985). From passive acceptance to active commitment: A model of feminist identity development for women. The Counseling Psychologist, 13, 695-707.

Dressler, W.W. (1986). Unemployment and depressive symptoms in a southern black community. The Journal of Nervous and Mental Disease, 174, 639-645.

Dressler, W.W., & Badger, L.W. (1985). Epidemiology of depressive symptoms in black communities. The Journal of Nervous and Mental Disease, 173, 212-220.

Eldredge, K.L., & Agras, W.S. (1996). Weight and shape overconcern and emotional eating in binge eating disorder. The International Journal of Eating Disorders, 19, 73-83.

Espin, O.M. (1994). Feminist approaches. In L. Comas-Diaz & B. Greene (Eds.), Women of color (pp. 265-286). New York: Guilford Press.

Fava, M., Abraham, M., Clancy-Colecchi, K., Pava, J.A., Matthews, J. & Rosenbaum, J.F. (1997). Eating disorder symptomatology in major depression. Journal of Nervous and Mental Disease, 185, 140-144.

Fernandez, M.E., Mutran, E.J., Reitzes, D.C., & Sudha, S. (1998). Ethnicity, gender, and depressive symptoms in older workers. The Gerontologist, 38, 71-79.

Fisher, B.J. & Hartman, D.J. (1995). The impact of race on the social experience of college students at a predominantly white university. Journal of Black Studies, 26, 117-133.

Fitzgibbon, M.L., Spring, B., Avellone, M.E., Blackman, L.R., Pinitore, R., & Stolley, M.R. (1998). Correlates of binge eating in Hispanic, Black, and White

women. International Journal of Eating Disorders, 24, 43-52.

Fleming, J. (1983). Black women in black and white college environments: The making of a matriarch. Journal of Social Issues, 39, 45-54.

Fleming, J. (1984). Blacks in College. San Francisco: Jossey-Bass Publishers.

Fredenberg, J.P., Berglund, P.T., & Dieken, H.A. (1996). Incidence of eating disorders among selected female university students. Journal of the American Dietetic Association, 96, 64-66.

Garner, D.M. (1991). Eating disorder inventory-2: Professional manual. Odessa, FL: Psychological Assessment Resources, Inc.

Gerdes, H., & Mallinckrodt, B. (1994). Emotional, social, and academic adjustment of college students: A longitudinal study of retention. Journal of Counseling and Development, 72, 281-INCOMPLETE!

Gibbs, J.T., & Fuery, D. (1998). Mental health and well-being of Black women: Toward strategies of empowerment. In P.B. Organista, K.M. Chun, & G. Marin (Eds.), Readings in Ethnic Psychology (pp. 367-385). New York: Routledge Press.

Gladdis, M.M., Wadden, T.A., Foster, G.D., Vogt., R.A., & Wingate, B.J. (1998). A comparison of two approaches to the assessment of binge eating in obesity. International Journal of Eating Disorders, 23, 17-26.

Gratch, L.V., Bassett, M.F., & Attra, S.L. (1995). The relationship of gender and ethnicity of self-silencing and depression among college students. Psychology of Women Quarterly, 19, 509-515.

Gray, J., & Ford, K. (1985). The incidence of bulimia in a college sample. International Journal of Eating Disorders, 4, 201-211.

Gray, J.J., Ford, K., & Kelly, L.M. (1987). The prevalence of bulimia in a Black college population. International Journal of Eating Disorders, 6, 733-740.

Greene, B. (1994). African American women. In L. Comas-Diaz & B. Greene (Eds.), Women of color (pp. 10-29). New York: Gilford Press.

Grissett, N.I., & Fitzgibbon, M.L. (1996). The clinical significance of binge eating in an obese population: Support for BED and questions regarding its criteria. Addictive Behaviors, 21, 57-66.

Grubb, H.J., Sellers, M.I., & Waligroski, K. (1993). Factors related to depression and eating disorders: Self-esteem, body image, and attractiveness. Psychological Reports, 72, 1003-1010.

Harris, D.J., & Kuba, S.A. (1997). Ethnocultural identity and eating disorders in women of color. Professional Psychology: Research and Practice, 28, 341-347.

Hawkins, R.C., & Clement, P.F. (1980). Development and construct validation of a self-report measure of binge eating tendencies. Addictive Behaviors, 5, 219-226.

Helms, J.E. (1984). Toward a theoretical exploration of the effects of race on counseling: A Black and White model. The Counseling Psychologist, 12, 153-165.

Henriques, G.R., Calhoun, L.G., & Cann, A. (1996). Ethnic differences in women's body satisfaction: An experimental investigation. The Journal of Social Psychology, 136, 689-698.

Higginbotham, E.B. (1992). African-American women's history and the metalanguage of race. Signs: Journal of Women in Culture and Society, 17, 251-274.

hooks, b. (1981). Ain't I a woman: Black women and feminism. Boston: South End Press.

hooks, b. (1984). Feminist theory: From margin to center. Boston: South End Press.

Hsu, G. (1987). Are eating disorders becoming more common in blacks? International Journal of Eating Disorders, 6, 113-124.

Hunter, A.G., & Sellers, S.L. (1998). Feminist attitudes among African American men and women. Gender and Society, 12, 81-90.

Jackson, A.A. (1992). A theoretical model for the practice of psychotherapy with Black populations. In A.K.H. Burlew, W.C. Banks, H.P. McAdoo, & D.A. Azibo

(Eds.). African American psychology (pp. 321-329).
Newbury Park, CA: Sage Publications.

Johnson, C., & Petrie, T. (1996). Relationship of gender discrepancy to psychological correlates of disordered eating in female undergraduates. Journal of Counseling Psychology, 43, 473-479.

June, L.N., Curry, B.P., & Gear, C.L. (1990). An 11-year analysis of Black students' experience of problems and use of services: Implications for counseling professionals. Journal of Counseling Psychology, 37, 178-184.

Jung, J., & Khalsa, H.K. (1989). The relationship of daily hassles, social support, and coping to depression in Black and White students. Journal of General Psychology, 116, 407-417.

Kensinger, G.L., Murtaugh, M.A., Reichmann, S.K., & Tangney, C.C. (1998). Psychological symptoms are greater among weight cycling women with severe binge eating behavior. Journal of the American Dietetic Association, 98, 863-869.

King, D.K. (1995). Multiply jeopardy, multiple consciousness: The context of a black feminist ideology. In B. Guy-Sheftall (Ed.), Words of fire: An anthology of African-American feminist thought (pp. 294-317). New York: The New Press.

Kuehnel, R.H., & Wadden, T.A. (1994). Binge eating disorder, weight cycling, and psychopathology. International Journal of Eating Disorders, 15, 321-329.

Laidlaw, T.A. (1990). Dispelling the myths: A workshop on compulsive eating and body image. In T.A. Laidlaw, C. Malmo & Associates (Eds.), Healing voices: Feminist approaches to therapy with women (pp. 15-32). San Francisco: Jossey-Bass.

Launier, R.A. (1997). Stress balance and emotional life complexes in students in a historically African American college. The Journal of Psychology, 131, 175-187.

Lee, N.F., Rush, A.J., & Mitchell, J.E. (1985). Bulimia and depression. Journal of Affective Disorders, 9, 231-238.

leGrange, D., Telch, C.F., & Agras, W.S. (1997). Eating and general psychopathology in a sample of Caucasian and ethnic minority subjects. International Journal of Eating Disorders, 21, 285-293.

Lester, R., & Petrie, T.A. (1998). Physical, psychological, and societal correlates of bulimic symptomatology among African American college women. Journal of Counseling Psychology, 45, 315-321.

Mallinckrodt, B. (1988). Student dropout intention: Comparison of Black and White students. Journal of College Student Development, 29, 60-64.

Marcus, M.D., & Wing, R.R. (1987). Binge eating among the obese. Annals of Behavior Medicine, 9, 23-27.

Marcus, M.D., Wing, R.R., Ewing, L., Kern, E., Gooding, W., & McDermott, M. (1990). Psychiatric disorders among obese binge eaters. International Journal of Eating Disorders, 9, 69-77.

Marcus, M.D., Wing, R.R., & Hopkins, J. (1988). Obese binge eaters: Affect, cognitions, and response to behavioral weight control. Journal of Counseling and Clinical Psychology, 56, 433-439.

McGrath, E., Keita, G.P., Strickland, B.R., & Russo, N.F., (Eds.), (1990). Women and depression: Risk factors and treatment issues. Washington, DC: American Psychological Association.

Mintz, L.B., & Betz, N.E. (1988). Prevalence and correlates of eating disordered behaviors among undergraduate women. Journal of Counseling Psychology, 35, 463-471.

Mitchell, A., & Herring, K. (1998). What the blues is all about: Black women overcoming stress and depression. New York: Berkley Publishing Group.

Molloy, B.L., & Hertzberger, S.D. (1998). Body image and self-esteem: A comparison of African-American and Caucasian women. Sex Role, 38, 631-643.

Murrell, S.A., Himmelfarb, S., & Wright, K. (1983). Prevalence of depression and its correlates in older adults. American Journal of Epidemiology, 117, 183-185.

Mussell, M.P., Mitchell, J.E., Weller, C.L., & Raymond, N.C. (1995). Onset of binge eating, dieting, obesity, and mood disorders among subjects seeking treatment for binge eating disorder. International Journal of Eating Disorders, 17, 395-401.

Nangle, D.W., Johnson, W.G., Carr-Nangle, R.E., & Engley, L.B. (1994). Binge eating disorder and the proposed DSM-IV criteria: Psychometric analyses of the Questionnaire of Eating and Weight Patterns. International Journal of Eating Disorders, 16, 147-157.

Neville, H.A., Heppner, P.P., & Wang, L. (1997). Relations among racial identity attitudes, perceived stressors, and coping styles in African American college students. Journal of Counseling and Development, 75, 303-311.

Nevo, S. (1985). Bulimic symptoms: Prevalence and ethnic differences among college women. International Journal of Eating Disorders, 4, 151-168.

Orbach, S. (1988). Fat is a feminist issue: A self-help guide for compulsive eaters. New York: Berkley Publishing Group.

Ossana, S.M., Helms, J.E., & Leonard, M.M. (1992). Do "Womanist" identity attitudes influence college women's self-esteem and perceptions of environmental bias? Journal of Counseling and Development, 70, 402-408.

Parks, E.E., Carter, R.T., Gushue, G.V. (1996). At the crossroads: Racial and womanist identity development

in Black and White women. Journal of Counseling and Development, 74, 624-631.

Peterson, C.B., Mitchell, J.E., Englebloom, S., Nugent, S., Mussel, M.P., Crow, S.J., & Miller, J.P. (1998). Binge eating disorder with and without a history of purging symptoms. International Journal of Eating Disorders, 24, 251-257.

Phillips, L., Tiggemann, M., & Wade, T. (1997). Comparison of cognitive style in bulimia nervosa and depression. Behaviour Research and Therapy, 35, 939-948.

Pike, K.M., Loeb, K., & Walsh, B.T. (1995). Binge eating and purging. In D.B. Allison (Ed.), Handbook of assessment methods for eating behaviors and weight-related problems (pp. 303-329). Thousand Oaks, CA: Sage Publications.

Pinkowish, M.D. (1995). Eating disorders: No stereotypes need apply. Patient Care, 29, 13-14.

Poindexter-Cameron, J.M., & Robinson, T.L. (1997). Relationships among racial identity attitudes, womanist identity attitudes, and self-esteem in African American college women. Journal of College Student Development, 38, 288-296.

Powell, A.D., & Kahn, A.S. (1995). Racial Differences in women's desire to be thin. International Journal of Eating Disorders, 17, 191-195.

Rand, C.S.W., & Kuldau, J.M. (1990). The epidemiology of obesity and self-defined weight problem

in the general population: Gender, race, age, and social class. International Journal of Eating Disorders, 9, 329-343.

Reed, M.K., McLeod, S., Randall, Y., & Walker, B. (1996). Depressive symptoms in African-American women. Journal of Multicultural Counseling and Development, 24, 6-14.

Robinson, P., & Andersen, A. (1985). Anorexia nervosa in American blacks. Journal of Psychiatric Research, 19, 183-188.

Root, M.P.P. (1990). Disordered eating in women of color. Sex Roles, 22, 525-536.

Rosewater, L.B., & Walker, L.E.A. (1985). Feminist therapy: A coming of age. In L.B. Rosewater & L.E.A. Walker (Eds.), Handbook of feminist therapy (pp. xix-xvii). New York: Springer Publishing Company.

Rouse, B.A. (Ed.). (1995). Substance abuse and mental health statistics sourcebook (DHHS Publication No. (SMA) 95-3064). Washington, DC: Superintendent of Documents, U.S. Government Printing Office.

Rucker, C.E., & Cash, T.F. (1992). Body images, body-size perceptions, and eating behaviors among African-American and white female college women. International Journal of Eating Disorders, 12, 291-299.

Sands, T. (1998). Feminist counseling and female adolescents: Treatment strategies for depression. Journal of Mental Health Counseling, 20, 42-54.

Schroeder, K. (1979). Blacks in college. Education Digest, 62, 74-75.

Schwitzer, A.M., Bergholz, K., Dorre, T., & Salimi, L. (1998). Eating disorders among college women: Prevention, education, and treatment responses. Journal of American College Health, 46, 199-208.

Silber, T.J. (1986). Anorexia nervosa in Blacks and Hispanics. International Journal of Eating Disorders, 5, 121-128.

Smedley, B.D., Myers, H.F., Harrell, S.P. (1993). Minority-status stresses and the college adjustment of ethnic minority freshmen. Journal of Higher Education, 64, 434-453.

Smith, B. (1995). Some home truths on the contemporary black feminist movement. In B. Guy-Sheftall (Ed.), Words of fire: An anthology of African-American feminist thought (pp. 254-267). New York: The New Press.

Smith, E.J. (1981). Mental health and service delivery systems for black women. Journal of Black Studies, 12, 126-141.

Smith, A.J., & Siegel, R.F. (1985). Feminist therapy: Redefining power for the powerless. In L.B. Rosewater & L.E.A. Walker (Eds.), Handbook of feminist therapy: Women's issues in psychotherapy (pp. 13-21). New York: Springer Publishing Company.

Smolak, L., & Levine, M.P. (1994). Critical issues in the developmental psychopathology of eating disorders.

In L. Alexander-Mott & D.B. Lumsden (Ed.), Understanding eating disorders (pp. 37-60). Washington, DC: Taylor & Francis.

Sowell, T. (1972). Black Education: Myths and tragedies. New York: David McKay Company.

Spitzer, R.L., Devlin, M., Walsh, B.T., Hasin, D., Wing, R., Marcus, M., Stunkard, A., Wadden, T., Yanovski, S., Agras, S., Mitchell, J., & Nonas, C. (1992). Binge eating disorder: A multisite field trial of the diagnostic criteria. International Journal of Eating Disorders, 11, 191-203.

Spitzer, R.L., Stunkard, A.J., Yanovski, S., Marcus, M.D., Wadden, T., Wing, R., Mitchell, J., & Hasin D. (1993). Binge eating disorder should be included in the DSM-IV: A reply to Fairburn et al.'s "The classification of recurrent overeating: The binge eating disorder". International Journal of Eating Disorders, 13, 161-169.

Sprock, J., & Yoder, C.Y. (1997). Women and depression: An update on the report of the APA Task Force. Sex Roles, 36, 269-303.

Stevens, J., Kumanyika, S.K., & Keil, J. (1994). Attitudes toward body size and dieting: Differences between elderly black and white women. The American Journal of Public Health, 84, 1322-1325.

Striegel-Moore, R., & Smolak, L. (1996). The role of race in the development of eating disorders. In L. Smolak, M.P. Levine, & R. Striegel-Moore (Eds.), The

developmental psychopathology of eating disorders:
Implications for research, prevention, and treatment (pp.
259-284). Mahwah, NJ: Lawrence Erlbaum & Associates.

Striegel-Moore, R.H., Wilson, G.T., Wilfley, D.E.,
Elder, K.A., & Brownell, K.D. (1998). Binge eating in an
obsess community. International Journal of Eating
Disorders, 23, 27-37.

Stunkard, A.J. (1959). Eating patterns and obesity.
Psychiatric quarterly, 33, 284-295.

Taylor, J.Y. (1999). Colonizing images and
diagnostic labels: Oppressive mechanisms for African
American women's health. Advances in Nursing Science, 21,
32-50.

Taylor, U. (1998). The historical evolution of Black
feminist theory and praxis. Journal of Black Studies, 29,
234-253.

Telch, C.F. (1997). Skills training for adaptive
affect regulation in women with binge-eating disorder.
International Journal of Eating Disorders, 22, 77-82.

Telch, C.F., Agras, W.S., & Rossiter, E.M. (1988).
Binge eating increases with increasing adiposity.
International Journal of Eating Disorders, 7, 115-119.

Thompson, B.W. (1992). A way outa no way: Eating
problems among African-American, Latina, and white women.
Gender and Society, 6, 546-561.

Thompson, B.W. (1994). A hunger so wide: A multiracial view of women's eating problems. Minneapolis: University of Minneapolis Press.

Thompson, B.W. (1994). Food, bodies and growing up female: Childhood lessons about culture, race and class. In P. Fallon, M.A. Katzman, and S.C. Wooley (Eds.), Feminist perspectives on eating disorders (pp. 355-378). New York: Guilford Press.

Thompson, C.E. & Fretz, B.R. (1991). Predicting the adjustment of Black students at predominantly White institutions. Journal of Higher Education, 62, 437-450.

Villarosa, L. (1994). Dangerous eating: The results of our survey on eating disorders show that black women are at risk. Essence, 24 (9), 19-23.

Ulbrich, P.M., Warheit, G.J., & Zimmerman, R.S. (1989). Race, socioeconomic status, and psychological distress: An examination of differential vulnerability. Journal of Health and Social Behavior, 30, 131-146.

Walker, A. (1983). In search of our mother's gardens. San Diego: Harcourt Brace Jovanovich.

Walsh, J. (1997). Binge-eating that plagues adults now recognized as a disorder. Environmental Nutrition, 20, 1-3.

Warren, B.J. (1994). Depression in African-American women. Journal of Psychosocial Nursing, 32, 29-33.

Wenk, D., & Hardesty, C. (1993). The effects of rural-to-urban migration on the poverty status of youth in the 1980s. Rural Sociology, 58, 76-92.

West, C. M. (1995). Mammy, Sapphire, and Jezebel: Historical images of black women and their implications for psychotherapy. Psychotherapy, 32, 458-466.

Wilcox, C. (1997). Racial and gender consciousness among African-American women: Sources and consequences. Women and Politics, 17, 73-94.

Willcox, M. & Sattler, D.N. (1996). The relationship between eating disorders and depression. The Journal of Social Psychology, 136, 269-272.

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