Eating Disorders in Women Across Cultures

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Eating Disorders in Women Across Cultures
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EATING DISORDERS ACROSS CULTURES

Eating Disorders in Women Across Cultures

Eating disorders are afflicting disorders that affect the mental and physical functioning of many. A review of nearly fifty years of research confirms that anorexia nervosa, one type of eating disorder, has the highest mortality rate of any psychiatric disorder with the ratio of observed to expected deaths (the standardized mortality ratio) reaching 5.86 (Arcelus, Mitchell, Wales, & Nielsen, 2011). The ratios of other psychiatric disorders are much smaller in schizophrenia (2.5), and bipolar disorder (1.21), respectively. Since anorexia’s original inclusion in the Diagnostic and Statistical Manual of Mental Disorders in 1952, rates of eating disorders diagnoses have increased from cases being found in less than 1% of the population to close to 3% in the population (Hudson et al., 2007; Streigel-Moore & Franko, 2003; Wade et al., 2011).

Originally thought to be limited to upper class Anglo-American women, eating disorders are now being seen in other ethnicities. The prevalence of eating disorders is reaching parity among Anglo-Americans, Latin Americans, and African-Americans (Hudson et al., 2007; Wade et al., 2011). Comparing different types of eating disorders across ethnic groups, there is an equal distribution of anorexia and bulimia, with only anorexia nervosa being more prevalent in Anglo-Americans (Hudson et al., 2007; Wade, Keski-Rahkonen, & Hudson, 2011). With more eating disorders occurring in the three largest group populations in the United States, a better understanding of their potential causes is needed as well as more studies across ethnic groups. Biological, historical, and sociocultural explanations have been used as models for the causes for eating disorders. With these factors affecting each ethnicity differently, more attention should be directed towards the influence of culture.

The following paper explores how different models of eating disorders are applied to women across ethnic groups in the United States. How Anglo-American, African-American, and Latin American cultural norms alter models of eating disorders is discussed. It is argued that although various explanations for eating disorders can be applied to those with the disorder, causes of behavior must be examined keeping cultural norms in mind.

Diagnostics

Feeding and eating disorders are characterized by continuous conflicts with eating or eating related behaviors that affect an individual’s consumption habits. Poor psychosocial functioning in these individuals impairs their physical health. There are six different eating disorders described in the Diagnostic and Statistical Manual of Mental Disorders including
rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, and pica. Although their classifications are distinct and defined by a specific set of symptoms, symptoms of more than one eating disorder can be present. Setting strict standards for diagnosis can be both limiting and incomplete. For this reason, future approaches to diagnosis should be more tailored towards the cultural beliefs of the population being examined. The eating disorders examined in this paper will be on anorexia nervosa, bulimia nervosa, and binge eating disorder.

Anorexia Nervosa

For a woman to be diagnosed with anorexia nervosa three criteria must be met including exhibition of persistent energy intake restriction, an intense fear of becoming fat, and a disturbance in the way they view their body weight and shape (American Psychiatric Association, 2013). The defining factor in this diagnosis that separates anorexics from bulimics and binge-eaters is the intense fear of gaining weight. Typically this extreme fear of becoming fat is not alleviated by weight loss (American Psychiatric Association, 2013). As anorexics lose more weight, the pressure to keep their weights at the newest obtained weight can build, or even increase fear. There are two subtypes of anorexia nervosa including the restricting type and binge-eating purging type.

In the restricting subtype of anorexia nervosa weight loss is achieved via dieting, fasting, and or excessive exercise. For the binge eating or purging type, recurrent episodes of binge eating or purging behavior must occur within a three-month frame. When someone has an eating disorder they typically fall into a concrete category (anorexia nervosa, bulimia nervosa etc.) but may crossover on various occasions when it comes to the symptoms they exhibit.

Bulimia Nervosa

Like anorexia nervosa, bulimia nervosa has diagnostic criteria that are both specific to its disease and that are more general to eating disorders at large. For bulimia nervosa, disordered eating is defined by recurrent episodes of binge eating, inappropriate compensatory behaviors to prevent weight gain, and the occurrence of either of these behaviors weekly for three months (American Psychiatric Association, 2013). The defining factor that separates bulimics from anorexics and binge-eaters is the act of purging as a compensatory behavior.

Various methods are utilized by bulimics to purge. Individuals commonly eat their fill until purging is necessary to receive relief from physical discomfort. Another tactic used includes
only eating a small amount of food and then shortly afterwards forcing themselves to vomit. Purging may have the immediate effect of reducing a disordered woman’s fear of gaining weight, but these sentiments do not normally persist in the long run (American Psychiatric Association, 2013). Instruments or fingers may be used to trigger a gag reflex to initiate purging. Purging behaviors can also consist of using aids leading to intentional misuse of laxatives, diuretics, or implementation of enemas. Prior to purging, bulimics typically binge eat.

Binge eating is defined as eating an excessive amount of food in a limited period of time. A span just short of two hours is considered to be a limited period (American Psychiatric Association, 2013). Excessive food consumption must elicit a lack of control in a bulimic to be considered a binging episode. Bulimics, compared to binge eaters, normally fall into a more generalized pattern of uncontrolled eating while binge eaters experience sporadic episodes (American Psychiatric Association, 2013).

One area where evidence of bulimia can generally be found is in the mouth. Mouth damage from purging can lead to loss of dental enamel, chipped and ragged teeth, enlarged salivary glands, and scars or calluses on the dorsal surface of the hand from repeated contact with teeth. Other rare but possible side effects from purging include esophageal tears, gastric rupture, as well as cardiac arrhythmias. Just as anorexia and bulimia can elicit life-threatening conditions from the behaviors involved in the disease, so can binge eating disorder.

**Binge Eating Disorder**

Binge eating disorder has specific diagnostic criteria that separate it from other eating disorders as well as from pure obesity. Binge eating is defined by recurrent binge eating in discrete periods of time without control. Binge eating episodes in order to be considered disordered must exhibit at least three of four traits defined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5). The four traits include eating more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, or feeling alone because of embarrassment from eating excessively.

The feature of binge eating disorder separates it from bulimia, is the absence of compensatory behaviors. Due to this feature, those with binge eating disorder typically are normal weight, overweight, or obese. Obese individuals with the disease are more likely to evaluate their body weight and shapes than obese individuals who do not binge.
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Seeing that binge eating disorder is correlated with a higher weight it has a more consequences regarding physical functioning in addition to impaired well being. Binge eating can cause social adjustment problems, poor quality of life and satisfaction, high levels of morbidity and mortality, and increased health care utilization (American Psychiatric Association, 2013).

Issues with Diagnosis

Having strict standards and approaches for the diagnosis of eating disorders can be limiting. Women who may fall on the cusp of being disordered may be excluded from diagnosis, and therefore excluded from treatment as well as from social support. In order to properly target women with eating disorders, diagnosis must be more receptive to symptom, weight, and perception differences of women across cultures.

Normally, women are first diagnosed by basis of survey and self-report questionnaires (Cummins, Simmons & Zane, 2005). This method is largely used in empirical research to determine eating disorder behaviors in populations. However self-reports can be biased and inaccurate in assessing eating disorder symptomology. To truly understand the nature of a woman’s eating behavior, and accurately assess diagnosis, face-to-face interview is necessary (Hsu, 1996). Therefore initial diagnosis needs to be more thorough as well as attentive. Also with eating disorders already occurring at low rates in the population, large sample sizes need to be used to detect disordered eating in non-clinical samples.

Another issue is reliance on the DSM. Simply looking at the DSM over time, changes in diagnostic criteria have occurred. For example, since 1980, the third edition, third edition revised, fourth edition, and fifth edition of the DSM have been released. With each version, criteria have been added, eliminated, and changed. Therefore whether or not women met criteria for anorexia or bulimia may depend on what criteria were being used at the time. Also with binge eating disorder being a new diagnosis, many obese women have likely been mislabeled and have not been receiving proper treatment. With the passage of time diagnosis for these reasons has not only been limited but variable.

Finally, symptoms that women with eating disorders present could vary across cultures. King (1993) found that the DSM’s diagnostic criteria best characterize Anglo-Americans. Since the DSM’s standards were originally generated from studies of mostly Caucasians living in western countries, the current standards best reflect the Anglo-American population (Mumford,
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1993). Therefore applying the DSM to African-American and Latin-American subpopulations may be less relevant than its application to Anglo-American populations. Different patterns of symptom presentation may exist cross-culturally, not aligning to the specific symptom sets applied to each specific eating disorder in the DSM. Similarly, tools to analyze eating disorder symptoms may not be applicable to non-White populations. For example the Eating Disorder Inventory may be more sensitive to eating pathology in whites than in blacks (Wildes, Emery & Simons, 2001). Therefore in future examinations, the tools used, the attention paid, and the thoroughness of evaluation in women across ethnic groups will need to be greater to detect eating disorder symptomology

Weight Differences

The body types that anorexia nervosa, bulimia nervosa, and binge-eating disorder yield differ due to differences in eating pathology for each disorder. In order to distinguish each disorder from the other, beyond visual and physical appearance, the Body Mass Index (BMI) is used. A person’s BMI is measured by dividing their weight in kilograms by their height, in meters, squared. As described by the Center for Disease Control, an adult falling at a BMI of 18.5 kg/m$^2$ is considered to be at the lower end of normal weight. Once an individual falls below a BMI of 17.0 kg/m$^2$ they are considered to be underweight and at risk for an eating disorder. Unlike anorexics who typically fall below a BMI of 18.5, bulimics typically fall between a BMI of 18.5 and 30. Therefore bulimics present as normal weight or overweight. Those with binge eating disorders respectively typically have larger BMIs, ranging from normal weight (18.5-30) to overweight (30+).

BMI measures can be misleading for both adult and adolescent populations. While particular ranges have been suggested to demonstrate physical health, variations in muscle mass and frames can leave individuals outside these ranges. Just because individuals fall outside these ranges, doesn’t mean they are not healthy. With BMI being included as a determinant of eating disorders, very high or very low numbers warrant concern for adults, with different numbers being less clear for adolescents. The reason behind this is as kids reach puberty, their bodies begin to change and grow at different rates. While some women may reach their full height by age twelve others may not do so until their late teens or even early twenties. As their bodies mature, their body shape’s change and their fat deposits typically increase in size. However if an eating disorder has developed at young age, delayed puberty can occur, bringing about additional
development problems. This being the case, the Center for Disease Control uses the BMI on an age basis, and considers those falling below the fifth percentile for their age to be underweight during adolescence.

BMI’s can also be a source of conflict when examining eating disorders across ethnic groups. As shown in Arriaza and Mann’s (2001) study of college-aged women, when BMI is controlled for, differences in Asian, Anglo-American, and Latin American women on the subscales of the Eating Disorder Examination Questionnaire (EDE-Q) disappear. In the study Asian had the lowest BMIs, with Anglo-Americans being in the middle, and Latin-Americans having the largest BMIs. The four subscales of concern for the EDE-Q included restraint, eating concerns, weight concerns and shape concerns. Before controlling for BMI Anglo-American women reported more restrained eating than Latin Americans, and Asians while Latin Americans showed significantly more weight and shape concern than Anglo-Americans and Asians. In the sample as BMI increased restraint eating concerns, weight concerns, and shape concerns increased. However, once BMI was controlled for only Anglo-American women still exhibited statistically significant levels of restrained eating, compared to their Asian and Latin-American counterparts. Differences between weight and shape concern were no longer statistically significant.

When comparing cultures, or large samples, controlling for BMI can lead to more accurate results. Where ethnic differences in body weight stem from is difficult to determine. Arriaza and Mann (2001) postulated that specific norms about beauty, genetic predisposition, environmental factors, and socioeconomic status might help explain ethnic weight differences; however no causal relationship has been determined. In future diagnostic procedures it may be useful to have specific BMI ranges for each ethnic groups presentation of eating disorders, rather than having ranges for just each disorder. Controlling for women’s size relative to the size of other women in their same cultural group would increase the accuracy of other measures. If control is not to be used, then it could be helpful to include a score that determines how much a woman’s BMI deviates from the average BMI of her cultural group (Holmqvist & Frisén.)

**Body Distortion**

A criterion that applies to all eating disorders is an internalized distorted view of the body. Body dissatisfaction is one of the strongest predictors of eating disorder development (Cooley & Toray, 2001; Cook-Cottone & Phelps, 2003; Hesse-Biber, 1996). An eating disorder
patient is typically extremely dissatisfied with her size, shape, or some other aspect of body appearance (Cash & Deagle 1996). Women, more than men, tend to over evaluate their weight and shapes. For example, Cash and Henry’s (1995) study found that 48% of non-clinical adult women have a negative overall appearance evaluation, with 63% not being satisfied with their weight, and 49% being preoccupied with the possibility of being overweight. While body distortion is widespread in the general population of women, its experience is even higher in those with eating disorders. Cash and colleagues (1996) meta analysis found that on average female eating disorder patients distorted their size to a greater extent than 73% of controls, with their level of body dissatisfaction exceeding 87% of the controls. Therefore women with eating disorders are exceptionally, although not distinctively, critical of their body size, shape, and appearance.

In their experience of body distortion it is also common for women to focus on “problem areas” which are parts of the body that bring them dissatisfaction. Areas of focus among women include the abdomen, buttocks, and thighs (American Psychiatric Association, 2013). Evaluation of the body can be both qualitative and quantitative including frequent weighing, measuring of body parts circumferences, continuous viewing of oneself in the mirror, and examining the tightness of clothes (Cash, 1995). These rituals can require a great deal of time and energy and normally interfere with everyday functioning. Women with eating disorders will organize their daily schedules around these monitoring activities.

Looking at eating disordered populations, bulimics compared to anorexics, tend to experience higher body distortion. Cash and Deagle’s 1996 meta analysis revealed that the average bulimic evaluated her body more negatively than 90% of controls, whereas the average anorexic’s discontent only exceeded 73% of controls. Possible reasons for this could be the greater variation bulimics experience in body size. As they go through bingeing and purging cycles, their body weights fluctuate. At times when bingeing is the dominant behavior, it is possible that women’s views of the body as large, is accurate. However when they slim down, they may still view themselves as the larger figure.

In line with body distortion, those with eating disorders typically fail to recognize their malnourished states. Malnourishment not only leads to being underweight but also can cause amenorrhea, a loss of bone mineral density, constipation, abdominal pain, cold intolerance, lethargy, and the growth of lanugo. Malnourishment constantly plagues anorexics, but also
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affects bulimics inconsistently.

Measurements of body distortion can also be an issue, when not separated from weights or BMIs. Typically comparisons of a woman’s current weight compared to her ideal weight are used to determine body distortion. If a woman desires a body that is smaller than her current size, than she is said to experience body distortion. When ideal versus desired weights are not measured on the same medium then levels of body distortion can appear larger than they real are. For example if obese women choose their ideal weight from a series of line drawings, and they choose a figure that resembles that of an average woman, then there level of body distortion will simply appear larger due to the discrepancy between their larger weights and the weight correlated with the drawing. However that they desire to be of average weight is likely a healthy choice, showing that they want to improve their overall health. Across ethnic groups a desired average weight most likely varies and should be accounted for. Overall perception of what is ideal can be highly variable. Therefore when measuring body distortion the same medium should be used to compare ideal and desired weights; either pounds to pounds or drawings to drawings.

**Biological Approaches**

Alternative explanations for eating disorders can come from a more inherent perspective. As products of evolution, development of eating disorders may more simply be expressions of adaptive mechanisms (Salmon, Crawford, Dane, & Zuberbier, 2008). With the presence of the proper environmental and social cues, modern day women may exhibit eating disorder behaviors as a form of protection from potential threats. These potential threats include food availability, food accessibility, other women, and the environment that women function in. These threats may serve as determinants for the eating practices that women exhibit.

*Environment and Economics*

One factor that can affect a woman’s attitude towards the amount of food she consumes is the general amount of food available to her. From an ancestral perspective, if a woman has frequent access to food then there is less worry about consuming higher volumes of food. In contrast if there are concerns about food accessibility, women from areas of food shortages may be more likely consume more food when it is available. Similarly if a woman predicts she will have less access to food in the long term then she could produce a larger body size in order to support herself for potential spans without food (Anderson, Crawford, Nadeau & Lindberg, 1992). These cues are also stimulated as a means to keep a woman in the healthy weight range
times, an obsession with slimness is characteristically concentrated in cultures where food is
abundant (Polivy & Herman, 2002). In cultures of scarcity, where a woman has minimal access
to food, the ideal body shape is much more likely to be heavier (Polivy & Herman, 2002). Both
extremes can lend themselves to eating disorders. Food choice also plays a large role in the
variance of a woman’s size.

In Dressler and Smith’s (2013) study women’s food choices, eating behavior, and food
preferences were examined. The ethnicities of the women were not specified. Although
differences in food preferences among normal weight and overweight women exist, the main
determinant of a woman’s food choices was her income. Lower income women may not have
access to highly nutritious food in addition to having less frequent access to food. Their diets
tend to consist of more refined grains, saturated fat, added sugars and sodium (Guenther, Jensen,
Batres-Marques, & Chen, 2005). Due to the geographical location of lower income
neighborhoods, low-income households are also more prone to eat fast food in order to get more
food for less money (Dressler & Smith, 2013). Additionally lower income neighborhoods can
reside in food deserts, lacking access to fresh, healthy and affordable food; limiting its residents
to fast food and convenience stores with minimal options (USDA, 2014). Due to these
circumstances, obesity is disproportionately prevalent in low-income, minority populations in the
United States (Ball & Crawford, 2005).

Women with lower levels of income tend to be from minority groups (Williams, 2002).
Across ethnicities, in 1995, the median wealth of Anglo-American households ($49030) was
almost seven times that of African-American ($7073) and Latin-American ($7255) households
(Davern & Fisher, 1995). There are also large racial differences in home ownership, a key source
of wealth for the average American family. Fewer than half of African-American and Latin-
American households owned their homes (1998), compared with more than 70% of White
households (Council of Economic Advisers for the President’s Initiative on Race, 1998). With
reduced sources of income, and poor nutrition, women of minority groups tend to have more
health problems in general (Williams, 2002). Some of these determinants have to do with the
structure of high poverty neighborhoods.

Minority groups are more likely to live in highly segregated neighborhoods with a greater
concentration of poor people (Massey & Denton, 1993). These communities tend to have limited
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exercise facilities and reduced opportunities to engage in physical exercise under conditions of assured safety (Lacar, Soto & Riley, 2000). Examinations of perceived safety, physical activity levels, and access to safe facilities have been studied among highly impoverished areas. In Romero’s (2005) study, 74 adolescents from a mid-sized city in the Southwestern United States were asked to fill out a survey that included measures of exercise frequency, after-school time demands, perceived quality of facilities, and perceived safety. The sample was comprised primarily Mexican-Americans, accounting for 56 of the participants. The results revealed that on average the sample exercised 3.53 days a week, with males reporting more physical activity (M=4.97), then females (M=2.35). With regard to time demands, only 14.5% reported having a job while 91% reported working less than 10 hours a week. As far as facilities were concerned, subjects who perceived facilities to be of higher quality and who had higher perceptions of environmental safety were more likely exercise frequently. The facilities that elicited the greatest amount of physical activity were after school programs. However men were significantly more likely to participate in afterschool programs then women. Participation in physical activity was defined as working out for at least 20 minutes that brought on sweating and hard breathing. Therefore the overall activity rates were very low in the sample. With conditions such as these, it is not surprising that both African American and Mexican American women are more than 1.5 times as likely to be overweight compared to White women (Williams, 2002). With all this considered there may be an interaction between food accessibility, food choice, and ethnicity. More women from minority groups may have lower incomes, which lead them to purchase less healthy food. Purchasing this food may be their only choice due to it being the only resources available to them.

Relationships between socioeconomic status and eating disorders can be seen at both higher and lower incomes across cultures. For example African-Americans women with higher incomes develop anorexia nervosa more frequently than their low-income counterparts (Anderson & Hay, 1985; Caldwell et al 2001). This could demonstrate that there is a relationship between middle and upper class weight standards and eating disorders. Looking at the other end of the spectrum, low-income women, being more prone to obesity would seem to be more prone to adopt binge eating disorder than high-income women. Recent data indicate that 37.4% of non-Hispanic black women and 34.2% of Mexican American women are obese, compared with 22.4% of non-Hispanic white women (Flegal, Carroll, Kuczmarski, & Johnson). Among these
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ethnicities, Latin-American women typically report themselves as heavier than they are and experience greater body distortion (Sánchez-Johnsen, Fitzbiggon, Martinovich, Stolley, Dyer, & Van Horn, 2004), potentially putting them at higher risk for an eating disorder.

*Climate*

It has been postulated that women who live in warmer climates are at higher risk for eating disorders (Anderson et al., 1992). In Sloan’s (2002) research the BMI’s and bulimic behaviors of Anglo-American, female, college students in Pennsylvania and Florida were compared. It was hypothesized that women residing in a warm weather climate would show increased eating disorder symptomology compared to women residing in a climate with seasonal variation. To identify probable cases of bulimia among the college women, the Bulimia Test Revised (BULIT-R) was used. Consistent with the prediction, the women at the southeastern college had significantly lower BMIs than the women in the northeastern region. Specifically, 19% of the women at the southeastern college had a BMI below 19 compared to only 1% of the women from the northeastern college. Also 20% of the southeastern women obtained scores on the BULIT-R that suggested probable diagnosis for bulimia nervosa, despite the sample being comprised of non clinical women. Therefore the warmer climate in the study presented more frequent bulimic behavior as well as more concerning BMI’s.

Although there may be a relationship between climate and body size this hypothesis may not hold when confounding variables are more closely examined. For instance, climate although fairly constant can still yield a variety of weather conditions that disrupt its consistency. However changes in weather are most likely not significant enough to immediately change an individuals behavior. As it becomes summer eating habits may changes, but they are not likely to reach the point of disorder. Also the college culture of the Pennsylvania campus may differ from the college culture of the Florida campus. A thinner standard of beauty and greater internalization of the thin ideal may be present on the Florida campus and absent on the Pennsylvania campus. Also appearance, aesthetics, and social life may be more highly valued at the Florida college while academics may be of higher importance at the Pennsylvania college. Overall the cultural dynamics of the campuses may lead to women to make local adaptations that highly influence their eating and weight management behaviors.

Katzmarzyk and Leonard (1998) found similar trends between climate and body morphology. In their meta analysis they postulated that thermal stress would dictate human body
size, due to humans’ tendency to adapt to their environments. Their hypothesis was based on the Bergmann rule (1897), which states, “within a polytypic warm-blooded species, the body size of the species usually increases with the decreasing mean temperature of its habitat.” The researchers believed that upon reviewing climatic BMI research in the second half of the twentieth century they would find support for the Bergmann rule.

The first study to find statically significant evidence of the BMI and climate relationship was Robert’s (1953) study titled “Body, weight, race, and climate.” Robert (1953) demonstrated a negative correlation between body mass and mean annual temperature in a sample of 149 subjects from anthropometric data. Since Robert’s (1953) study several authors have found regional relationships to climate and body size in Africa (Hiernaux & Froment, 1976), Europe and the Mediterranean (Crognier, 1981), and the New World (Newman, 1953; Newman & Munro, 1955; Stinson, 1990). Katzmarzyk and Leonard’s (1998) review since Robert’s study included 195 female samples. The ethnicities of the subjects included African, Australian, Melanesian, American, European, Central Asian, Easter Mongoloid, Polynesians, South Asian, and Indian. For females, BMI was significantly negatively correlated with mean annual temperature, although not as strongly as in Roberts (1953) sample. Since 1953 an increase in body mass of the general population was seen, with larger increases in tropical regions than cooler regions. Changes in body mass were attributed to food availability and nutrition which, as stately previously, could bring about environmental stress.

A possible explanation as to why women in cooler climates may be less prone to contracting eating disorders is due to their enhanced need for fat. Fat, aside from being an energy creating agent and storage center for vitamins and food material, provides insulation. Having fat keeps the body warm and is essential to survival in a colder climate, making it less of a necessity where it is warmer. This offers that women of cooler climates would value a fuller body shape, while women from warmer climates would prefer a slimmer one.

However this approach does not always hold. For example typically African-Americans are larger than Anglo-Americans. Despite their place of origin being much hotter than Anglo-Americans their typical body size does not conform to the thin standard. Once again, this suggests that there are confounding variables that hold a greater influence on the body weight and shape of women, and their eating habits. A woman’s culture of origin most likely has the greatest influence on her preferred body weight and shape as well as the eating habits she
succumbs to. While the environment she is functioning in may alter her behavior, causing her to make local adaptations, her perceptions of what is an ideal body will still influence and possibly drive her eating behavior and weight management.

**Reproductive Suppression**

Women may inherently manage their body weights due to perceived threats in their environments. Specifically, women with eating disorders may exhibit reproductive suppression as a means to protect themselves from an undesirable reproductive situation (Salmon, Crawford, Dane, & Zuberbier 2008). Reproductive suppression refers to a woman intrinsically decreasing her fat content as a means to protect herself from a current unfavorable possibility of reproduction, until she feels her situation has improved (Wasser & Barash 1983; Williams 1966). For adolescents, keeping body weight down can prevent the onset of ovulation. For adults, maintaining a lower weight can lead to amenorrhea preventing the necessary fertility for reproduction. If women feel pressure from their environment regarding negative attention from men as well as social competition from other women, the reproductive suppression could kick in intuitively.

Linda Mealey’s (1999) work argued female intrasexual competition is the driving factor behind reproductive suppression. She argues that dominant women bring about reproductive suppression in other women, in order to diminish resource competition. The mechanism that dominant women partake in to bring about reproductive suppression in their inferiors is reducing their social value. For example, Mealey (1999) gives the example of competitor derogation, which accounts for dominant women calling into question the sexual reputation of other women. Dominant women attempt to lower the worth of their potential competitors, seen as threats, by calling them out on their frequent participation in the mating process, reducing their potential fertility (Campbell, 1995). Seeing that women are more influenced by the opinions of other women that the opinions of men (Graziano, Jensen-Campbell, Shebilske, & Lundgren, 1993), these confrontations can hinder a women’s self view and in turn her reproductive physiology (Wiederman & Hurst, 1998). These confrontations could also explain why adolescents exhibit higher rates of eating disorders. As new mates on the market, adolescents may be the more frequent targets of dominant women (Pawloski & Dunbar, 1999).

In the modern day, the United States may present the appropriate conditions for reproductive suppression to occur. First as a theory, reproductive suppression explains why more
women are affected by eating disorders than men. Also with the United States being highly industrialized society, growing in affluence, environmental stressors and competition are high. These circumstances are applicable to women across ethnic and cultural groups. Seeing that the thin standard is imposed on women by women (Anderson, Crawford, Nadeau, & Lindberg, 1992) stress and competition is inherent within the sex.

Although all ethnicities may experience stress and intrasexual competition the choices women make regarding food intake to deal with stress could affect their appearance, leading women of different ethnic groups to have different bodies. For example even if an adaptive mechanism kicks in, women may still binge eat or cope with food that would yield them a body size that is still physically larger. Also if women are competing with other women for men’s attention, and the believe that a thinner figure is more attractive, then women may make their own choices to diet. Women could also receive high levels of social support that could allow them to confront threats more easily. Once again a woman’s perception of what is ideal, which is likely to be influenced by her home culture, may in the end determine the weight, shape, and eating habits of the modern woman.

*Waist to Hip Ratio*

Although humans need fat to function, women generally fear the stigma that it brings them (Levitt, 2004). In fact, women’s dissatisfaction with their bodies is such a widespread experience that high amounts of overlap in feelings about the body have been found between clinical populations of women with eating disorders and normal women (Rodin, Silberstein & Striegel-Moore, 1985). From an evolutionary standpoint, women’s fear of fat is illogical. Having more body fat, within a reasonable range, yields a higher probability of ovulation leading to both reproductive success and improved lactation during nursing (Anderson et al., 1992). Seeing that eating disorders lead to amenorrhea, being anorexic would consequently hinder a woman’s ability to reproduce. Although women may prefer to be thin to attract male mates, generally males do not prefer as thin a woman as women believe they do (Brown & Konner, 1987). In Swami’s (2010) analysis of the International Body Project men and women’s figure preferences based on attraction were rated. The study included men and women from 26 different countries, across 10 world regions. In the study the men and women were presented with a 9-figure scale of women and were asked to rate each figure on the degree physical attractiveness it presented. The rating were 1= not at all, 5= somewhat, 9= extremely respectively. The preferences of men and
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women were compared. The results revealed that men preferred a larger figure than their female counterparts. The only exception was East Asian men who preferred the moderately slender figure, which was also preferred by East Asian women. Ways that male preference has also been demonstrated includes ranking of waist to hip ratio, body weight, and body shape.

Waist to hip ratio (WHR) has been deemed a reliable measure of physical attractiveness due to its ability to assess the reproductive value of a woman (Buss, 1987; Symons, 1979). Waist to hip ratio values account for the distribution of gynoid and android fat about the body. Measurements include the waist, the narrowest portion between the ribs and the iliac crest, and the hips, the widest point of the body where the greatest protrusion of the buttocks occurs. Comparing the circumferences of these areas comprises a person’s WHR, ranging from 0 to 1. Ratios closer to 1 represent a more tubular figure while lower ratios represent a more hourglass figure. The typical range for healthy premenopausal women lies between 0.67 and 0.80 (Lanska, Hartz, & Rimm 1985; Marti, et al., 1991). Having a WHR within this range has been correlated with reproductive capability and overall health. Therefore if men value these attributes, as evolutionary theories suggest, Singh proposed than men should be able to assign attractiveness, health, and reproductive potential ratings accordingly to WHRs.

Figure 2. Stimulus figures representing three body weight categories: underweight (I), normal weight (II), and overweight (III). (Waist-to-hip ratios [WHRs] shown under each figure in each weight category, along with a letter and a number in parentheses identifying body weight category WHR).
Singh’s (1993) research tested this theory by having 106 men (72 Anglo-American and 34 Latin-American) evaluate 12 line drawings of female figures representing four levels of WHR and three levels of body weight (underweight, normal weight and overweight). The 106 subjects were asked to rank the 12 figures from most attractive to least attractive. They were then each asked to choose 6 figures, three high and three low, that they believed best-represented high good health, youthful appearance, attraction, and reproductive potential.

In both the underweight and normal weight categories, subjects ranked attractiveness as a function of WHR with the lowest WHR figures (0.7) being rated as most attractive. Comparing across weight categories, the “normal” body weight categories were ranked as the most attractive accounting for 65% of the subjects’ preferences. Although the underweight subjects were rated as more youthful, they were not perceived as more attractive. Inline with this result, underweight drawings with high WHRs were perceived as neither youthful nor healthy. Therefore, although a woman may be seen as youthful, having a pre-pubertal body may not be seen as attractive. Also the highest reproductive capability was assigned to normal weight subjects, and the lowest to underweight subjects.

Overall the women that were found to be the most attractive had a lower WHR and were of normal weight. The drawing that corresponded with normal weight and a low WHR (N7) was perceived as the healthiest and to be of highest reproductive success. Therefore men in this sample found a low WHR, and a normal body weight, not a low body weight and a tubular body to be representative of the best mates. Similar research across cultures has suggested the female shape that is most attractive is that of the nubile female (Brown & Konner, 1987).

**Historical Perspectives**

As stated by Erickson, “The fact is that in all periods of history, mental disturbances of epidemiological significance or special fascination highlight a specific aspect of man’s nature in conflict with the ‘times’.” For the twentieth century one of man’s conflicts of the times was with food. During this time period eating disorder awareness and discussion increased. Various factors are thought to have promoted disordered eating as well as began trends that still hold today in the 21st century. Society emphasized the importance of the body as an aesthetic entity. The connection between the body and beauty was heightened, and diet management was seen as the means to obtain what society deemed as aesthetically pleasing. For women the attainment of
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an ideal body by restrained food intake was deemed a high achievement. The following section will explore the conflicts women confronted with food and the socio-cultural changes that began to promote the thin body as the ideal body.

*The Roaring Twenties*

The most notable period where a slender physique for women was valued was the 1920s. The flapper era for women was a time when all women’s opportunities and roles were changing. There was a notable decline in motherhood rates, and increases in high school, college, and university attendance for women (Stearns, 1997). Becoming more independent, more women sought after jobs outside the home. Society was lending more power to women, but also beginning to demand more of them. Goals for appearance, weight, shape, were presented to the public.

Aesthetically, the fashion and cosmetics industries were booming as were beauty contests, modeling, magazines, and glamour in films. The fashion industry standardized clothing sizes by marketing ready to wear sizes in the “normative” range. This innovation increased emphasis on personal body size and began to set standards for acceptable weights. This was first seen in high fashion, trickling down to most clothing distributors shortly after. Essentially society was receiving a message that fat was no longer acceptable or considered normal.

An example of the initial stages of these product changes came from Chanel. Chanel was the first company to promote skimpier clothing; with a less is more approach. They specifically dropped the waistline to the hips and began to expose more of the leg (Brumberg, 1988). In 1922, Chanel further increased the body-exposing nature of their design by raising the hemline of their dresses to midcalf, which then moved up to just below the knee in 1926 (Brumberg, 1988). Dresses such as these not only called for a slim, but a bump free figure. With fashion revealing more and more skin, more discipline was obligatory to keep the trendy boyish form.

With fashion pushing women to be skinny, new tools came on the market to help achieve these looks. For example the use of the home scale became widely popular in the 1920s. Home scales provided a means to assess ones weight management (Stearns, 1997). Having the ability to view ones weight in the home allowed Americans to be more critical of their size from day to day. The scale could be a direct source of stress and guilt, for those who were incapable of conforming to the thin standard (Stearns, 1997). In this same decade, drugs and creams to help battle fat came on the market and increased in popularity. Amphetamines were particular popular
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for the battle against fat (Stearns, 1997).

Overall the culture of the twenties was a culture of reduction. Where fat and curves had once been correlated with wealth and the nurturing nature of being a woman, the power and control associated with thinness took over. Therefore not only the culture of the environment a woman functions in, but also how that environment changes over time, can affect her relationship with food and the body.

Dieting

The 20th century called for a new degree of weight management for all of society. From a medical and social standpoint Americans were expected to have their weights under control. As a consuming capitalist society, this presented a struggle in many aspects (Schwartz, 1986).

Medically, changes in weight standards, seen by the public in weight charts, called for Americans to be thinner and fitter. For example the Metropolitan Life Insurance Company, whose weight charts were used as the standard in hospitals, reduced their weight ranges for men and women between the early 1940s and late 1950’s (Schwartz, 1986). When this change occurred, the charts went from labeling weight as “ideal” to “desirable.” Simply by renaming the ranges from ideal to desirable demonstrates the tone of the century. Society no longer considered weight to be ideal, or something to be imagined as attainable, but as desirable. By terming the new weight standards as desirable, a smaller weight was wanted, being an attractive, useful, and necessary course of action.

These changes set the tone for the rest of the century, heightening the importance of the public’s relationship with food. Dieticians began to recommend exercise and discouraged eating between meals (Stearns, 1997). Food products were advertised based on their slimming qualities. The sale of diet goods alone rose at a 10% annual rate between 1960 and 1980 amounting for nearly 7% of all food sales (Schwartz, 1986). Also the number of diet books on the market grew exponentially, as did the availability of food substitutes. The second half of the century led to the most prominent rates of dieting. Seven percent of men and 14% of women professing to being on a diet in 1950, and those percent’s rose to 34% and 49% in 1973 (Stearns, 1997). Specifically in the early 1970’s, 72% of all dieters were women (Stearns, 1997). Although dieting was promoted from a healthy weight management and obesity prevention lens, its message reached women for additional reasons.

Diet discussion for women emphasized aesthetic factors over all others. Women were
encouraged to diet in order to fit into current styles, to avoid inordinate curves and protuberances, and for the basic reason that fat was now considered to be aesthetically unpleasant. Given the responsibility to feed their families, women were persuaded to prepare pleasing food that they themselves were discouraged to consume (Schwartz, 1986). Targeting women, the age of dieting behaviors decreased across the century. Studies suggest that girls sometimes as young as 8 or 9 partook in food restriction in the interest of not getting fat (Zaslow, 1986). Messages targeting young girls became more apparent from a variety of sources, including doctors, parents, and the media (Brumberg, 1988). Specifically magazines began to address the importance of appearance in adolescence.

Magazines

A highly accessible form of media that rose in popularity in the 20th century was magazines. Serving as sources of advice, magazines pinpointed trends that were prominent of the times. Magazines made the transition of targeting adolescent girls, claiming readers beyond housewives (Brumberg, 1988). *Ladies Home Journal*, a highly popular magazine began to promote vanity to its younger readers in the 1940s. The journal argued that appearance is too important to a girl’s life to not have her grow up beauty conscious. Essentially girls were encouraged to manage their appearance at a younger age than ever (Brumberg, 1988). Similarly in 1948, *Seventeen* magazine addressed being overweight as a medical problem. *Seventeen* began to educate its readers about calorie counting and the psychology of eating (Brumberg, 1988). Specifically girls and women were advised to go on sensible diets ranging from 1200 to 1800 calories (Brumberg, 1988). Overall these two magazines primarily have Anglo-American readers.

Magazines targeting specific ethnic groups also addressed weight management concerns. *Ebony*, a popular African American women’s magazine, discouraged its readers from fad dieting and instead encouraged that its readers consume food more sensibly by eating less fats and starches typical of “soul food” (Schwartz, 1986). Interestingly, according to *Ebony*, successful African American women would need to leave behind the traditional equation of fat with wealth and health typical to the African American culture (Schwartz, 1986). This suggestion was not widely accepted by its readers. Typically *Ebony* had expressed openness to women who were above a recommended healthy weight, supporting that African American men appreciated heft in their women (Stearns, 1997). Therefore although the magazine presented diet articles, there
frequency of appearance and the degree to which they were valued were lower.

It seems that society’s promotion of diet and exercise, portrayed throughout the media was reaching more ethnic women with less of an impact. Possibly due to less participation in the consumer society, African American and Latin American women weren’t feeling the pressure to conform to the thin ideal. Also depending on the types and amount of media they chose to consume (magazines, television, books), ethnic women may have received mixed messages. While the popular message was that of reduction, their cultural message may have been to continue working in order to provide for their families.

*Ethnic Women in the Mainstream*

While white women entered the work force in large numbers in the 1970’s and later, ethnic women were steadier in their contributions to the working world. Throughout the 20th century African American and Latin-American women continued to work, performing physical labor that demanded more strength and size (Stearns, 1997). Therefore a strong body was deemed a positive attribute representing beauty, strength, and power; this was in direct contrast to white middle class standards. For African American women particularly, providing for the family was nothing new. They were used to doing physical work. Therefore the culture of the times for ethnic women was very different than that of Anglo-Americans. Choosing to internalize their own values rather than what was popular for homogenic culture, ethnic women were not prone to adopt the thin standard.

In Latin-American culture specifically, value was placed on the ability to eat substantially as a sign of success. Largeness was highly correlated with marriage, and proper devotion to the family, health, and the home (Schwarts, 1986). Largely, the society that Latin Americans operated in was different than that of Anglo-Americans. Although they were contributing to society’s increased distribution of goods and services, they were not obtaining the “benefits” of these goods. Therefore lack of participation in the consumerist societies of the 20th century and valuing of a larger body size, and in turn their home cultures, worked against Anglo-Americans growing insistence on slimness.

Overall the lower socioeconomic status of African American and Latin American women in the 20th century provided a different perspective to the value of food and perceptions of a proper physique. It’s possible that instead of society recognizing differences across ethnic groups as cultural differences, ethnic groups have been discriminated against claiming that their high
weights and poverty stem from ignorance (Schwartz, 1986). To claim that they prefer to be fat and out of style is a insensitive way of cutting them off from the rest of society limiting them to small economic and social ranges. Failure to recognize progress for these women as different from progress of Anglo-American women leaves ethnic women unaccounted for as recipients of trends. It is possible that at the turn of the century, as ethnic women began to participate more in consumer society, there susceptibility to eating disorders rose as well. This could explain why eating disorders for African-Americans and Latin-Americans are a more recent phenomena.

Sociocultural Explanations

The majority of factors that have been said to contribute to the development of eating disorders are sociocultural. As women confront a culture that differs from their own, they receive various messages that tell them how they should look in regard to weight, shape, and beauty. Increased pressure from social groups (Zalta & Keel, 2006) and media (Silverstein, Perdue, Peterson, & Kelly, 1986) tend to influence how women deal with standards proposed by the United States at large. Across cultures, standards of beauty differ (Gray, Ford & Kelly, 1987). Dealing with the conflict between the culture at large, and a woman’s home culture can bring about additional stress for minority women. As they acculturate to Western society the struggle to hold on to their home culture and embrace a new culture can be difficult (Harris & Kuba, 1997). How they decide to confront this conflict can determine eating disorder symptomology. For the following factors it is important to remember that they are not causes of eating disorders. While these factors may increase women’s chances of developing eating disorders they in no way guarantee the development of an eating disorder.

Ideal Weight and Shape

Women tend to state that men prefer women with thin figures to any other type of woman. Research conducted by Fallon and Rozin (1985) shined light on the idea that men do not actually find super skinny women to be attractive. In their study 277 females and 248 males (ethnicities not specified) were asked to view a series of nine sketches of various body shapes and claim which body shape they believed best represented how they thought they looked (current), how they desired to look (ideal), which figure they believe would be most appealing to the opposite sex (attractive), and which opposite sex figure they found most attractive (other attractive). The results revealed interesting comparisons across genders.
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The females from the study tended to overestimate their shapes (chose a figure that was larger than their actual figure), and consistently chose a smaller ideal figure than their current figure. Women also consistently chose an ideal body figure that was smaller than the one they thought would be most attractive to men (Fallon & Rozin, 1985). Therefore women, by their own discretion, showed that they prefer to be thinner than what men desire. These finding demonstrate that women are driven to be thin by motives ulterior to attracting the opposite sex. Proposed possibilities for motives include the function of weight loss as a means of establishing control over one’s life and or the belief that others consider thinness in females to be a positive personal feature (Garner, Garfinkel, & Olmsted, 1983). As explained previously, women’s preference to be thin can also be attributed to reproductive suppression triggered by stress or by intrasexual competition with other females.

Comparing men’s preferences to women’s choices, the figures that women thought would be most attractive to men were much smaller than the figure men chose as their preference for the opposite sex (Fallon & Rozin, 1985). The males, unlike the women, overestimated the figure that women would find to be attractive, but men had no discrepancies in their perceived versus ideal figures. Therefore men did not desire to change their figures. Overall the study revealed that women have much higher body dissatisfaction as well as distortion and may choose to alternate their weight for their own personal reasons rather than for sexual pursuits (Fallon & Rozin, 1985). How this compares across ethnic groups has been minimally explored. Differences in body distortion have been found but the underlying reasons have not been addressed. Its possible that body distortion may exist in all groups but sources of dissatisfaction may be more culturally specific (Wildes, Emery, Simmons, 2001).

Women’s satisfaction with their body weight and shape is an area that differs across cultures. With different levels of body satisfaction, come different levels of body distortion. In Marian, Fitzgibbon, Blackman and Avellone’s (2000) study, African American, Latin American, and Anglo-American women were given a picture containing nine women of various body weights ranging from ultrathin to overweight. With this scaled image the 389 participants were asked to identify which weight best represented what they believed was their current body weight. Women were then asked to choose the shape that they considered to be ideal. The BMI of each participant was recorded for comparisons between Body Discrepancy and BMI.
Each group reported about the same degree of body discrepancy, meaning there was a difference between the figure they chose to represent themselves and the figure they chose to represent an ideal woman’s figure. The African American women on average had BMI’s that indicated them as obese (M=30.7). The Latin American women had BMI’s that indicated them as overweight (29.1), but not obese. The Anglo-American women were just under the criteria BMI of being overweight (M=25.9). The average body discrepancy for Anglo-American women was M=1.18, for African-American women M=1.13, and for Latin-American Women M=1.36. Seeing that body discrepancy ratings greater than zero indicated that the participant’s current body image was heavier than her ideal body image, displayed that all ethnic groups experienced body discrepancy, believing they were larger than ideal.

Marian and colleagues concluded that body discrepancy for Anglo-American women was experienced at a lower BMI than the other women. Therefore at lower weights they thought they were too large. The body discrepancy of African American women occurred at an obese BMI, meaning they did not desire to be thinner until they were already overweight. Latin-American women experienced body discrepancy at an overweight but not obese BMI level, falling above Anglo-American women but below African American women.

How Marian, Fitzbiggon, Blackman and Avellone discussed relationships between BMI and body discrepancy in their study could be misleading. As mentioned earlier, BMI’s tend to differ across ethnic groups and may not serve as the best representation of disordered eating. Although the ranges are accurate in determining weight status (underweight, average, overweight, obese) the labels they give may be misleading. For example African-American women tend to weigh more than Anglo-Americans and Latin Americans. Therefore the majority of their population may not fall in the average weight category. The overweight category, may serve as a better representation of their average weight. Therefore in Marian and colleagues study, their conclusions that African-American women experience body discrepancy by the time they’re overweight is misleading. Compared to other women from their home culture, they are most likely experiencing body discrepancy at an average weight. What the study should really be
concluding is that body discrepancy is not limited to a single group a women, but is experienced by all ethnic groups. Like other measurements and scales used in eating disorder research, sensitivity to ethnic variation needs to be considered.

What Marian and colleagues (2000) research did show was that Anglo-American women were most concerned on the degree to which their bodies differed from a thinner model. They also showed that the majority of the ethnic women in their sample were overweight with some being obese. Areas of concern that can be taken from this study, regarding eating disorders and mental health, could be women’s ignorance of being overweight. By failing to perceive the initial stages of being overweight as a problem, minority women can suffer from health problems that could have been avoided by maintaining a lower weight. If there weight issues stem specifically from overeating, then binge eating disorder can be of concern. Just as there is comfort in a larger size for binge eaters, there is some degree of comfort in a smaller size for some bulimics and the majority of anorexics. For anorexics it is important to distinguish that an intense fear of fatness rather than an overarching desire to be thin is prevalent.

By combining the research on the body shapes different women desire and how women relate their weights to these shapes, conclusions that anorexic women fear fatness rather than desire to be ultra thin have been made. Cserjési et al. (2010) supported this idea in his study. In the study 35 anorexia nervosa patients, who were residents of Belgium, evaluated body shapes while a control group of non-patients did the same. During analysis the results from both groups
were compared to each other. Both groups were given three types of silhouettes to judge including an overweight silhouette, an ideal silhouette and an underweight silhouette. The results revealed both differences and similarities between the two groups. While the anorexic patients rated the ideal silhouette significantly less positively and the overweight silhouette as significantly more negative than the non-patient group, both groups of women agreed that the ultra-thin body figure was negative. Studies such as support that those diagnosed with anorexia don’t necessarily desire to be super thin but rather fear becoming fat.

As seen in the studies mentioned, frequently body dissatisfaction as well as distortion are examined using figure-rating scales comparing female silhouettes across a spectrum. Although this method is frequently chosen due to its high comprehensibility and ease of administration, it may not be the best way to operationally define body dissatisfaction or distortion (Holmqvist & Frisén, 2010). The use of silhouette figures has been criticized heavily for its lack of sensitivity to personal perceptions, its restriction regarding response alertness, and in some cases the difficulty it can present in comparing adjacent figures (Gardner, Friedman, Jackson, 1998). Also figure rating scales do not account for distortion of specific body parts, only for distortion in size. Therefore women who are dissatisfied with a particular part of their body rather than their whole frame may go unnoticed in measures of body distortion.

*Standards of Beauty*

Anglo-American culture in the United States believes that a thin standard of beauty is ideal for women, meaning they believe a thin body is something that should be desired, wanted, and achieved. This standard has been embraced by a variety of sources but has been most widely identified to stem from the media. Main sources of media that portray the image of the thin woman include television, magazines, and film productions. One study that investigated these influences and opened up research in this field specifically was that of Silverstein, Perdue, Peterson, and Kelly (1986).

Silverstein and colleagues (1986) examined media to see if it played a role in reinforcing the pressure on women to be thin. Their research had the aims of demonstrating that media promotes a slimmer, more weight conscious standard for women than for men and that the standard of bodily attractiveness has become slimmer over time. These changes would align with changes that occurred historically at the turn of the century. They conducted three studies to test these notions. Their first study analyzed female television characters and compared their degree
of slimness to their male counterparts. Their second study analyzed magazine articles for the number of advertisements directed toward women to diet. Their third study analyzed the curvaceousness of females portrayed in the women’s magazines *Vogue* and *Ladies Home Journal* to see if women had become less curvaceous over time. The final study examined the curvaceousness of the most popular female movies stars of the past 50 years, to see if they had become more tubular over time. Assuming that Anglo-American women are the highest consumers of the sources studied, this research would be most representative of changes in their culture’s standard of beauty.

The results of the studies revealed that the standard of beauty for women over time changed from curvy to tubular. The first study found that 69.1% of the 82 women from 33 television programs were rated as thin compared to only 17.5% of their 139 male costars. The second study found that the total number of ads for diet foods in the 48 issues of the women’s magazines was 63 compared to only one in male magazines. In articles dealing with body shape or size, advertisements for nonfood figure enhancing products appeared 96 times in women’s magazines but only eight times in men’s. The third study showed that the bust to waist ratios in *Vogue* and *Ladies Home Journal* were highly correlated (.91), reflecting a similar standard of bodily attractiveness for women across female audiences. Looking at the bust to waist ratios over time, the ratios were lowest in 1925 and highest in 1909. From 1925 to 1949 there was a gradual climb in the ratio from 1.1 to 1.6. From 1949 to 1981 the ratio steadily declined to 1.2. Therefore in 30 years time the bust to waist ratio portrayed in women’s magazines has significantly decreased. In the final study the bust to waist ratios of 38 movie actresses was compared from 1933 to 1979. In the 1930’s the actresses were deemed non curvaceous, stemming from the thin boom of the 1920’s. From 1940-1959 the mean ratio was 1.34. For 1960-1979 the mean ratio was 1.22. Therefore with the passing of each decade, actresses’ shapes have become more tubular.

Combining the results of the four studies, Silverstein and colleagues (1986) provided evidence that at the end of the century women who are exposed to mass media are exposed to a standard of bodily attractiveness than is slimmer than men, and a standard that is thinner than in previous years. Assuming that Anglo-American women are the largest consumers of the sources of media in the study, these changes would be most representative of changes in their standard of beauty. A more recent meta analysis further confirms this change. Holmqvist and Frisen’s (2010)
analysis concluded that more affluent countries experienced greater body dissatisfaction due to having greater access to body centered information through television, newspapers, and the internet. Although the media may not be the only source promoting this standard its popularity brings concern about the influences it may press upon its audience.

With Anglo-Americans comprising the majority of women in the United States (195,148,000 civilians in 2012) (US Census Bureau, 2012), their standard of beauty dominates the media. While Latin American women and African American women comprise the second (52,358,000 civilians in 2012) and third (39,696,000 civilians in 2012) largest populations in the United States (US Census Bureau, 2012), their levels of concern with the media’s proposed standard of beauty may differ. For example Krapelin’s (2011) study examined the different media reading habits and Anglo-American, African-American, and Latin-American women. The study found that African American and Latina respondents’ magazine reading habits differed substantially. Frequencies showed that 76% of Latinas read a fashion/beauty magazine regularly, versus 41% of blacks. Forty-nine percent of African-Americans, read an ethnic magazine published for the black community. In contrast, Latinas did not read ethnic magazines developed for Latinos, despite the abundant titles available today, both in English and Spanish. Cross-tabulations of women’s ethnicities and the most popular magazine titles indicated that the differences in respondents’ magazine reading patterns were statistically significant (p<.05). Latinas were significantly more likely to read fashion and beauty books, specifically Cosmo Girl and Seventeen, while blacks were significantly more likely to read ethnic-oriented magazines, specifically Ebony, Essence, and Jet. These magazine preferences may speak to how women of different ethnic groups standards of beauty differ.

For example, African-American women who do not identify with Whiteness, more easily reject the Anglo-American proposed standard of thinness (Gray, Ford, & Kelly, 1987). Even though the average African-American woman may be heavier than her Anglo-American counterpart, the majority of African-American women report more positive attitudes about their body size compared to Anglo-Americans (Gray et al., 1987; White, Hudson, & Campbell, 1985). By African-American women having more accepting attitudes towards obesity, broader definitions of beauty, and a more multifaceted sense of self-esteem, African American culture may play a protective role in the incidence of eating disorders (Gray, Ford & Kelly, 1987).
Differences in self concept about the body have been examined across cultures, and on college campuses.

When comparing African American college women to Anglo-American college women, the level of dieting examined was the same but African American women were on average of a higher weight (Cashel et al., 2003). Also when comparing rates of awareness of the thin ideal, and the internalization of this concept, African American women obtained significantly lower scores on both facets than Anglo-Americans. African American women also obtained lower scores on their active drive for thinness and body dissatisfaction scales than their Anglo-American peers. Although African American women may be less influenced by media’s portrayal of a thin standard of beauty, Latin-American women tend to recognize it.

Latin-American women, alternatively seem to be more affected by the Anglo-American proposed standard of beauty. Pomper and Koenig (2004) analyzed two different generations (Generation X aged 18-35, and Baby Boomers aged 36 and over) of Latin-American women to compare their perceptions of magazines standards of ideal body image. The three research questions they proposed were how do Latin-American women regard magazines standards of the ideal body image, how might Latin-American women’s perception of the ideal body image change over time, and what role might language play in setting standards for Latin-American women’s perceptions of ideal body image? Responses were obtained by asking Latina women about their personal experiences from reading magazine and their magazine preferences using focus groups; which could have lead to response bias and socially desirable responding. However notable differences were found.

The magazines the Latina women reported reading most frequently included Cosmopolitan, People, In Style, Time, Newsweek, and Home and Garden. Generation X reported that magazines’ image of women made them more weight conscious while emphasizing that women must be skinny in order to be attractive and socially accepted. Both generations reported that the women in the magazines set the standard for ideal body image, but the older generation (Baby Boomers) rationalized that the ideal was impractical. Although Generation X women believed that the skinniest women in the magazines were too thin, most agreed that they would not mind being that skinny themselves. They admired the fuller figured women in the magazines but acknowledged that they were not considered socially acceptable.
Both groups of Latina women, when asked about cultural factors, acknowledged that Anglos prefer to be really skinny while the Latin culture is more accepting and respectful of a larger woman’s body. As mentioned previously, historically a larger size for Latin Americans has been correlated to representing proper nurturing of the household and providing a support system for their families. When comparing magazines published in English to Spanish, *People* and *People en Español*, the Spanish magazines seemed to correlate health and shape with being voluptuous and curvy. However both groups preferred English fashion magazines to Spanish fashion magazines. Overall it seems that Latin-American women recognize the cultural conflict of their minority group with the dominant Anglo-American culture. Although the magazines examined may have the intention to target a general audience, the values they promote may be more representative of Anglo-American culture. Unlike African American women, Latin American women seem to adopt the thin ideal as their standard of beauty.

An alternative explanation for why there may have been a difference in Baby Boomers and Generation X’s reactions to media could be a matter of maturation. Heatherton, Mahamedi, Striepe, Field, and Keel’s (1997) conducted a longitudinal study of Caucasian college students body weights, dieting, and eating disorder symptoms from college to 10 years after graduation. The goal of the study was to examine how the participants eating behaviors and body satisfaction changed as they transitioned into adulthood. The data was obtained by administering a survey once in college, and ten years later. The questionnaire distributed including demographic questions, general eating patterns, dieting history, body weight and shape concerns, abnormal eating behaviors, and frequency of abnormal eating behaviors. The survey was first distributed in 1982, and then redistributed in 1992. The results revealed more dieting and eating disorder symptoms while in college than in adulthood. Both men and women had gained weight since college with women gaining an average four pounds and men gaining on average twelve pounds. Interestingly women who had weighed more than the average women in the sample in college and who had had less concerns about being thin in college were more likely to have gained weight after college. For men being thin in college was a predictor of weight gain after college. Since women had left college they no longer viewed themselves as overweight or very overweight and had less of a desire to want to lose weight. Dieting behavior in women increased for 18% of the sample, remained the same for 37% of women, and decreased for 45% of women.
As for eating disorder attitudes, there was a significant decline in bulimic attitudes and a strong decline for drive for thinness for women.

Overall women’s relationship with their bodies and food changes as a function of maturation. This relationship could also change based on changes in stressors as one ages. Very few of the women in the study were satisfied with their bodies in college, and although body dissatisfaction and dieting continued it occurred at lower rates. The improvements seen in the data, support that there is an age-related decline in disordered eating.

Another more specific reason that women’s attitudes towards the body and eating, as well as standards of beauty differed could be the cohort they pertain to. In Heatherton and colleagues (1997) study, the Caucasian women being examined were adolescents at a time when eating disorders were becoming common knowledge. By being teenagers in the 80’s its possible that the sample was more susceptible to patterns of disordered eating (Heatherton, Polivy & Herman, 1991). In Pomper and Koenig’s (2004) study similar reasoning could be applied to the Baby Boomer Group.

In order to gain a better understanding of standards of beauty in the future, and how these standards relate to weight and shape more longitudinal studies need to be conducted, especially among minority groups. Seeing that many minority women may experience greater changes when going through transitions in life, seeing how their perceptions of beauty change or remain would be helpful in deciphering normal versus disordered eating behaviors. Also more studies need to be conducted on the longitudinal, natural history of eating disorders, focusing on women who may not pursue treatment or be strictly labeled as having a mental disorder. Seeing that many women fall into the Eating Disorder Not Otherwise Specified (EDNOS) category, with approximately 30% of college women displaying disordered behavior without meeting all disorder critetion (Heatherton, Nichols, Mahamedi, & Keel, 1995), having more research target these groups can help manage undesirable behavior that could lead to a disorder at a later time.

College and Social Groups

College students exhibit particularly high rates of eating disorders (Fairburn, 1990). Prevalence estimates range from 8% to 17% (Hoerr, Bokram, Bivins, Keast, 2002; Kirk, Singh & Getz, 2001; Prouty, Protinsky, & Canaday, 2002; Reinking & Alexander, 2005). In 2005, The National Eating Disorder Association reported that 20% of respondents from a national survey of college students suspected they had suffered from an eating disorder at some point in their lives.
Also the American College Health Association’s National College Health Assessment in 2008 revealed that 3.5% of females and 0.4% of males had received a diagnosis of anorexia; 2% of females and 0.2% of males for bulimia; and 4% of females and 1% of males reported vomiting or taking laxatives in the past 30 days in order to lose weight. This highlights the increased density of eating disorder behavior on college campuses.

Various factors can be attributed to eating disorders in the college setting. One factor can be the transition young adults confront when leaving home and starting a new phase of independence. When young adults start college, the influence of their peers is heightened in the absence of their guardians and by the increased peer proximity of college living situations (Zalta & Keel, 2006). With the roles of peers being amplified, college women typically desire to fit in to certain social groups and tend to adjust their behaviors to do so. With thinness being highly valued in college culture (Levitt, 2004), appearance is typically used as a means to conform.

Anglo-American thinness, or conformity to the dominant standard of beauty in the United States, may be perceived as a way to achieve social acceptance and approval (Levitt, 2004). This notion pushes a drive for thinness in college women. The perception that develops is that thinness is required for success and acceptance. Therefore failure to achieve thinness can lead women to experience personal and social failure (Gilbert, 2000). By receiving approval and social acceptance (positive reinforcement) in the achievement of a thin figure, being thin becomes a motivating force behind college women’s eating behaviors. Drive for thinness can therefore be a factor leading to the development of eating disorders in the college setting.

One group where this sentiment seems to uphold is among sororities. In Allison and Park’s 2003 study sorority and non sorority women’s disordered eating habits were examined over time. A Caucasian sample of 205 women were followed over their college experience and measured on 3 separate occasions. At Time 1 and Time 3 women’s ideal weights were assessed. At Time 2 women’s sorority membership or lack of membership was accounted for. At all three times scales for drive for thinness, bulimia, body dissatisfaction, depression, self-esteem, and the Eating Disorder Inventory 2 were administered. The results revealed that sorority women gained more weight over the three years than non-sorority members. Sorority members reported consistent drive for thinness over time while non-sorority members scored lower on this variable over time. Therefore Greek life involvement kept women concerned about being thin as they aged in college. Where drive for thinness may decline after the transition is made from high
school to college, sorority membership continues the belief that being thin is necessary to fit in. Similar sentiments could be experienced in other college organizations, especially groups that promote similarity rather than diversity. Therefore being members of racially unified groups could also promote standards for inclusion.

It is not only a drive for thinness but a fear of fatness that mediates college women’s eating behaviors. Just as many positive attributes are related to thinness many negative attributes are related to fatness. Typically being fat is viewed as unsightly and unhealthy (Gaesser, 1996). With college women believing that social success in college depends on appearance and acceptance, fear of fat could be related to fear of exclusion. Research has also supported that there are high levels of weight-based discrimination for women in their college years (Canning & Mayer, 1966; Crandall, 1991). These sources may not be limited to institutions.

Past research has shown that parents’ perceptions of their daughters’ success based on their weight may influence their decisions in supporting the daughters financially in their pursuit of higher education. Crandall’s (1995) study examined women’s weight and their main sources of financial support. Ethnicities of the participants were not specified. Since fat is stereotyped as being correlated with laziness and lack of self discipline, the more parents apply the stereotype to their offspring the more likely they are to believe that their daughters would be unlikely to succeed in or benefit from higher education. Therefore the hypothesis of the study was that women who pay for their own college education should be fatter than women who receive funding from home. The results revealed a statistically significant difference in the BMI’s of girls who supported themselves and girls who were supported by their parents. Heavyweight females were significantly more likely to be supporting themselves in college. This relationship was not mediated by ability to pay; confirming that who paid for the daughters’ education was based on attitudes towards her perceived abilities and weight, not her financial situation. Relations such as these may only encourage disordered eating, in order to please others.

Similarly avoidance of weight gain could be a behavior related to active avoidance of disapproval from others. Avoidance behavior could come from negative reinforcement, with women avoiding weight gain in order to avoid teasing, shame, and discrimination. With fear of fatness serving as diagnostic criteria for anorexia nervosa, internalizing this fear can be correlated with eating disorder symptomology.
With college women pushing to manage their weights as a means of social acceptance, a cycle of weight loss and weight gain can develop (Hesse-Biber, 1996). College women may restrict their food intake, which can in turn promote overeating. Pushing to once again be thin can lead to dieting and excessive exercise; which in the end just leads to more superfluous eating. Even if a woman is capable of achieving her ideal body she still has to actively work to maintain her weight. This brings additional pressure and work for her to remain thin. Throughout the cycle, behaviors correlated with eating disorder diagnosis can arise. Women may begin to purge or binge out of the sight of others (Cashel, Cunningham, Landeros, Cokley & Muhammad, 2003). They may also begin to significantly suppress their food intake, exhibiting anorexic behavior. Overall weight management can trigger stress and lead to inconsistent eating. Sources of stress in college can also be external to weight management and contribute to eating disorder behavior.

Increased academic rigor as well as competition can bring about stress to college students of all ages. For women specifically there may be heightened competition in mate seeking behavior. Competition for male attention can bring confrontation and threats of violence from other women into higher proximity (Hesse-Biber, 1996). Also women are more likely to have multiple partners in college causing a higher risk of unwelcomed reproduction. Stressful times can be poor times to breed for women at any age. For this reason, women may be more inclined to fall into patterns of reproductive suppression (Salmon, Crawford, Dane & Zuberbier, 2008).

In studies using college samples, Anglo-American women reported significantly more symptoms of eating disturbance and body dissatisfaction than African American women (Wildes, Emery & Simons, 2001). With Anglo-American women accounting for the majority of college samples participants it is difficult to make solid conclusions across ethnic groups. If African-American and Latin-American women were studied more frequently, than differences in eating behaviors would be easier to detect. Also simply attributing smaller attendance rates to lower rates of eating disorders lends to lack luster analysis and a missed opportunity. By more closely examining the smaller African-American and Latin-American college women populations’ researchers could possibly decipher how college culture (primarily seen as Anglo-American) affects non-Anglo-American women. With college being driven by the media, social groups, competition, intellect, higher education, and white affluence, women are constantly exposed to potential causal factors of eating disorders. This is most likely why women who identify with
college culture more closely identify with Anglo-American culture and therefore report more symptoms of eating pathology (Davis & Yager, 1992).

**Acculturation**

Acculturation is defined as the process of incorporating the norms of a new culture into one's life. Through the process of acculturation an outsider gains knowledge of the new culture’s language, values, and practices (Castro, Coe, Guitertes, & Saenz, 1996). For an outsider representing heterogeneous culture, adaptation of the homogenous culture can be a difficult and long process. Symptoms of poor mental health are commonly produced from such strain. Therefore acculturation conflicts can be linked to eating disorder pathology.

A large source of stress in the acculturation process can be sorting the through conflicting ideals of the home culture and new culture. In Harris and Kuba’s (1997) research, eating disorders for women of color were attributed to the interactions between ethnocultural identity confusion and conflicts in cultural concepts of beauty and attractiveness. Eating disorders from the researchers perspective could be understood as a woman’s manifestation of the conflict between acceptance and rejection of cultures:

The compulsive eater diets compulsively. She is trapped in her vacillation between adopting a rigid Eurocentric view of beauty (when she is dieting severely) and rejecting this view (during binges). The resultant heaviness of her body may be a metaphor for a desire to be recognized and acknowledged by rejecting a culture that defines beauty as thinness. The bulimic presents a similar cycle of internalized oppression (purging) followed by rebellion against that oppression (bingeing). In contrast to the compulsive eater the bulimic cycle occurs on a daily basis. Such frequency of the cycle may indicate that the bulimic is more plagued by this conflict than her compulsive eating peers because her purging results in a slimmer body. The purging may be an attempt to rid herself of the shame attached to her body as well as the shame she feels in rejecting her own cultural values.

There is desire to fit in to a proposed standard as well as acknowledge a woman’s home culture. Women of color are torn. Feeling obligated to submit to the Anglo-American standard of beauty, participation in compensatory behaviors might arise. Whether this model is applicable on a larger scale is debatable.
For women from minority groups, acculturative stress can be heightened by the college experience and increase the probability of mental health problems and coping behavior (Mori, 200). The acculturative stress that college brings can pose a threat to first generation students more so than students whose parents attended college. In Mena, Padilla, and Maldonado’s (1987) research they compared the acculturative stress of 214 multicultural college students. The students were divided into four groups including early immigrants (immigrated before 12 years of age), late immigrants (immigrated after age 12), and second-generation and third generation. The researchers examined how acculturative stress differed across groups. The results revealed that late immigrant students experienced the highest levels of acculturative stress and coped with stress by personal means. In contrast, second and third generation groups coped using their social networks, which normally consisted of women from their home culture.

Acculturation is a controversial factor as a determinant of mental health problems. For example there is a tendency to misjudge degree of acculturation to begin with. A common assumption is that younger generations are more acculturated simply due to their earlier exposure to the host culture (Rogler, Cortes & Malgady, 1991). Although this relationship was found in Mena, Padilla and Maldonado’s (1987) study, acculturation isn’t necessarily a function of time spent in the host country. Differing degrees of acculturation can stem from differences in the immigration experience, the historical period an individual is operating in, their current stage of the life cycle, social mobility, and economic status. Also there tends to be the assumption that as an outsider of the host culture beginning to adopt to the new culture, leads to a loss in the home culture (Rogler, Cortes & Malgady, 1991). Assuming that acculturation is a weighed process isn’t always the case. Each individual varies on the degree that they affiliate with their home culture and their host culture.

As for acculturation and mental health status there is mixed literature on whether it helps or hinders immigrants’ functioning. As a negative correlation, choosing to not adopt the values of the host culture can leave an individual isolated and cause them to experience strain from being unfamiliar with the host environment. Without learning the skills and norms of a culture, the environment that the immigrant is functioning in remains uncontrollable (Rogler, Cortes & Malgady, 1991). Lacking a sense of control can lead to lower self-esteem and lead to mental dysfunction. As a positive correlation, high levels of acculturation can detach a person from their home culture’s support systems. Attempts to act like those from the home culture can lead to
stereotyping and the experience of prejudicial attitudes. Also high degrees of acculturation in the US can lead to increased alcohol and drug abuse, which can impair functioning. All these factors can lead to mental disorders (Rogler, Cortes & Malgady, 1991).

For this reason, more longitudinal studies of acculturation need to be conducted. By looking at the relationship between acculturation over time, it is likely that a curvilinear relationship will present itself (Rogler, Cortes & Malgady, 1991). If researchers are able to conduct multiple studies that confirm this notion then the inconsistencies in literature can simply validate that both the initial stages and the later stages of the acculturation process are stressful but the process as a whole leaves an individual more comfortable in their host environment.

Applying acculturation to eating disorders, rates in Latin American women are comparable to that of Anglo-American women (Bruce & Agras, 1992; Crago, 1996). When acculturation conflicts are present, Latin American women tend to have higher internalization of the thin ideal. Austin and Smith (2008) supported this relationship in their study on a population of public school girls ages 12-15. Austin and Smith looked specifically at the sociocultural model of eating disorders within this population. According to the sociocultural model, adolescent girls receive consistent messages from their social environment (e.g., parents, peers, and the media) that a very slender physique is attractive, desirable, and preferable. The extent to which girls internalize, or personally subscribe to the thin ideal varies.

The participants were asked to provide their weights and heights as well as complete a number of surveys regarding their attitudes towards the feminine physique. The surveys that the girls completed included The Figure Rating Scale, The Eating Attitudes Test, The Body Shape Questionnaire, The Sociocultural Aptitudes Towards Appearance Questionnaire (SATAQ), and the Attitudinal Familial Scale. More than 70% of the girls were of average BMI’s while the remaining participants were at risk for being overweight or were overweight. For data analysis the girls were divided into the normal weight category or the at risk/overweight category respectively.

The results for each survey varied among groups. On average participants viewed their actual body size as larger than their ideal body size. On The Figure Rating Scale that consisted of nine bodies to choose from no participants selected an ideal body size that was larger than the fifth figure (the average sized figure). At large, 12.4% of the sample chose the anorexic body size (the smallest sized figure) as their ideal figure. Over half of the normal weight girls (51.1%)
experienced body discrepancy. The at-risk/overweight group had an even larger body image discrepancy than the normal weight girls. The at-risk/overweight group also had higher Eating Attitude Tests’ scores than the normal weight girls. Higher scores on this test indicate higher concerns for disordered eating. Following the trend, the SATAQ scores of the at-risk overweight group were significantly higher than the normal weight girls. Higher SATAQ scores indicate greater awareness as well as internalization of the thin ideal.

The results indicate points of concern in populations of young Latin American girls. While the normal weight group scored high in eating disorder behaviors, symptomology, body dissatisfaction, body discrepancy and thin ideal internalization, the at-risk/overweight group scored even higher. This may demonstrate that Latin American commonly present symptoms of binge-eating disorder. One factor that is seen to be protective for Latin American women is that of familismo.

Depending on the families’ personal beliefs about treating illness, getting support for minority women with eating disorders can be difficult. If the family adopts a more traditional approach to medicine then it is possible that clinical treatment may be largely avoided. For example, fatalism is a commonly shared belief among Latin American families that life events are pre-determined and that there is nothing that can be done to change their course (Rodríguez, Ramírez, Davis, Patrice & Bulik, 2013). Other cultural preferences in the Latin American community that have served as barriers to treatment include a high need for privacy, pride in showing strength, and a fear of being perceived as having a weak character (Becker, 2010). Some Latin-Americans cultural beliefs may promote better health and support systems in the home.

Familismo in the Latin American culture has been shown to play a protective role in Latin Americans onset of eating disorders. Familismo describes a commitment to family relationships over individual needs (Andrés-Hyman, Ortiz, Añez & Davidson, 2006). For Latin Americans the concept of family goes beyond the nuclear family extending to grandparents, relatives, and close family friends. This collectivist approach has been related to various positive youth outcomes in adolescents including less aggressive outbursts, safer sexual practices, reduced alcohol and substance abuse as well as higher levels of self-esteem. Assuming that a Latin-American woman values familismo more so than her social group’s perspectives in adolescence, the degree to which societal influence of eating disorders can affect her can be
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reduced. If a Latin-American woman however, is more individualistic or finds it difficult to assimilate, then she may turn to processes such as disordered eating to achieve a look that she believes makes her “fit in.”

In line with familismo, the input of extended family in decision-making as well as in approaching medical conditions is largely valued in minority cultures. Commonly, family issues are approached within the family nucleus until alternative methods are necessary. With the widespread support that extended family brings, minority women may be protected from some correlates of eating disorders and if they are at risk may have more direct support than that of their Anglo-American counterparts.

Certain cultural practices may play a protective role for women of color, while other practices may lead to disordered eating. Women of color may more frequently turn to food as a coping mechanism, which can lead to binge eating directly and at a later time lead to compensatory behaviors. Reasons that women from these groups may turn to binge eating is to cope and escape from heightened self-awareness (Heatherton & Baumeister, 1991). It is possible that both drive for thinness and bulimic behaviors help alleviate acculturative stress in these groups (Heatherton & Baumeister, 1991). Although thought to help, these behaviors may serve as maladaptive coping strategies that are used in an attempt to attain the Anglo-American thin ideal. This could serve as an explanation as to why binge eating rates among women of color have reached comparable levels to Anglo-American women.

Past research has found that in some cases women of color display binge eating disorder symptomology more frequently than their Anglo-American counterparts. Fitzgibbon and colleagues (1998) study compared the severity and correlates of binge eating disorder in 55 Anglo-American, 179 African-American, and 117 Latin American women. In addition to examining eating disorder behavior using the Questionnaire on Eating Patterns and Weigh- Patterns revised and the Binge Scale, the researchers examined how weight and ideal body image correlated to binge eating disorder severity.

Across groups, Latin-American women reported more binge eating and more severe binge eating than Anglo or African-Americans. Specifically, 9.6% of the Latin-American women met the criteria for BED compared to only 3.9% of African-American women and 1.8% of Anglo-American women. Also Latin-American women chose a slimmer ideal body image than both Anglo-American and African-American women. Weight wise, Latin-American women and
African-American women were heavier than Anglo-American women but equally so. For Latin-American women, as BMI increased eating disorder symptoms worsened. In total the results of these measures speak highly to eating disorder symptomology. For example despite Latin-American women weighing significantly more than the Anglo-Women, they reported similar body image ideals. Conversely even though the Latin-American women weighed similar to the African-American women, they still reported a lower body image ideal. The disparity experienced between the actual and ideal body weight may speak to a dilemma for some Latin-American women’s’ aspiration to assimilate without the ability to attain or maintain a low weight (Fitzgibbon et al., 1997).

A similar study compared just African-American women with binge eating disorder to Anglo-American women with binge eating disorder. In, Streigel-Moore, Pike, Wifely, Dohm and Fairburn’s (2001) study a group of 52 black and 98 white women with binge eating disorder were compared to 150 race matched control women. Pike and colleagues hypothesized the African-American women with binge eating disorder would be comparable to Anglo-American women with binge eating disorder in their behaviors but that African-American women would report less weight and shape dissatisfaction. Participants completed the Eating Disorder Questionnaire, were interviewed using the Eating Disorder Examination Questionnaire, and completed the Brief Symptom Inventory.

Upon completion of the study, the researchers observed that although both groups of binge eating disordered women were obese, the African-American women in the control group were also obese. Among women with eating disorders, black women had significantly lower scores than white women in eating, shape and weight concern. African-American women binged more frequently (5.99 times per week) than Anglo-Americans (3.88 times per week). Also although African American women binged more frequently and were more obese, Anglo American women were significantly more likely to report alcohol abuse, dependence, or a history of bulimia nervosa. What can be drawn from this is that cultural differences can account for behavioral differences, as well as mentality differences. For example although African American women have greater acceptance of a larger figure they may be less prone to seek treatment. In addition to lower treatment seeking behavior in African American women with binge eating disorder, the likelihood of receiving mental health care is low for racial minority groups (Kessler et al., 1999; Olfson & Pincus, 1994).
While the role of non Anglo-American group membership may serve a protective function in some cases it may increase the risk of disordered eating in others. While African-Americans culture may be more dismissive of the host culture, Latin American culture may be more susceptible to the negative influences of Anglo-American culture. This adaptation can lead to internalization of the thin ideal, greater body distortion, as well as the development of disordered eating (Wildes, Emery & Simons, 2001). The different types of eating disorders that manifest may also be variable. While African American women may be more susceptible to binge eating disorder (Streigel-Moore & Smolak, 1996), Latin American women may be more likely to develop bulimia (Crago, 1996). Overall although rates of eating disorders are lower in ethnic groups, they are on rise (Weiss, 1995). If eating disorder analysis were more inclusive of culture, accounting for variances in weight and shape, differences in standards of beauty, differences in milestone experiences, and differences in acculturation then the incidence of eating disorders could be better understood, regulated, and treated.

Factors Influencing Treatment Success

Despite anorexia nervosa, bulimia nervosa, and binge eating disorder sharing common characteristics in diagnostic, behavioral, and psychological attributes, these disorders differ in the manner they are exhibited over time and their treatment needs (American Psychological Association, 2013). Personal factors tend to dictate both the pursuit and success of eating disorder treatment programs. While particular factors may increase the probability of recovery others can lead to resistance and relapse. With the inclusion of culture as an influence, future research could target what can be done to improve prevention and recovery from eating disorders.

Potential Barriers to Treatment

Women from minority groups who have eating disorders are typically un-diagnosed, under diagnosed or don’t pursue treatment for their diseases (Cachelin, Rebeck, Veisel, Streigel-Moore, 2000). The rate of minority women in clinics is very low (3-5%), even in cities with large minority populations (Strober, 1999; Wilfley, 1999). This is concerning with the frequency of eating disorders in these groups being similar to that of the Anglo-American population (Cachelin et al.,2000; Cachelin, Striegel-Moore, & Elder, 1998). With the recent growth in eating disorders in minority women Cachelin, Rebeck, Veisel and Streigel-More compared rates of women who seek treatment and women who do not. They hypothesized that Anglo-American
women would be more likely to have sought treatment than minority women.

Of the 61 women, who all met diagnostic criteria for an eating disorder, 57% (35 women) sought treatment and only 8% (5 women) received proper treatment for an eating disorder. Therefore although women in the sample had access to care, they were not receiving the care they specifically needed. Across minority groups, 42.9% of the Latin-American, 20% of the African American, and 25.7% of the Anglo-American women sought treatment. Across eating disorders, 1 of 5 anorexics, 10 of 17 bulimics, and 21 of 33 binge eaters sought treatment. Possible reasons for not seeking treatment from most prominent to least prominent included financial difficulties, lack of insurance, the belief that others can't help, fear of being labeled, not knowing about resources, feelings of shame, fear of discrimination, turning instead to other sources, belief that they did not have a problem, counselors not being of the same ethnic background, and lack of transportation. Although this study accounted for trends at large, there are personal factors that may influence the direction of treatment for eating disorders in minority women.

For minority women, difficulties that may be experienced on a more personal level include feelings of shame, worries about being labeled, qualms regarding discrimination, or reservations concerning stigma (Kline, 1996). Fears of the treatment environment are also common. Common fears minority women have about receiving treatment in clinical settings include patients’ discomfort about being separated from their families, not believing that counselors are credible sources of help, expectations that counselors will be hostile or cold, and experiences of general unfamiliarity of mental health services (Cachelin et al., 2000). There are also general system barriers that are more commonly felt across minority populations. Barriers can include language difficulties, lack of health insurance, lack of transportation, lack of knowledge of available resources to treat their symptoms, or no childcare to allow adults to go to appointments. While barriers may be present for women of all ethnicities with eating disorders, their families’ personal beliefs may greatly influence whether or not they seek traditional treatment.

Treatment resistance is a common occurrence across psychiatric disorders (Posee & Nemeroff, 2012). Resistance is particularly high in eating disorders with anorexia nervosa leading to the highest dropout rates; ranging from 20 to 51% for inpatients and 23 to 73% for outpatients (Kaplan & Garfinkel, 1999; Fassino, Pieró, Tomba & Abbate-Daga, 2009). Abbate-
Dage, Amianto, Delsedime, De-Bacco and Fassino (2013) examined current literature on the treatment of eating disorders to uncover what most commonly leads to resistance of treatment. Two of the thematic areas they explored included denial of illness and motivation to change.

Seventy-one articles were included in the overview. The ethnicities of the patients in the meta-analysis were not specified. Beginning with denial, more treatment resistant patients showed clear denial of illness rather than minimal insight of illness (Konstantakopoulos, Tchanturia, Surguladze, David; 1951-1961). Denial of illness was defined as the refusal to acknowledge and or accept ones disorder; referring not only to individual defense mechanisms but also to disadaptive coping (Gabbard, 2012; Fabbri, Fava, Sirri & Wise, 2007). Across studies it was seen that poor insight, or high denial, could be maintained even in the chronic phase of eating disorders. Treatment effectiveness was hindered by patients’ inability to recognize their behaviors as an illness.

Motivation to change also affected the degree of resistance across studies. Three studies found that an independent willingness to recover was an absolute requirement to demonstrate preparation for change (Nordbo, Espeset, Gulliken, Skarderud, Geller, & Holte, 2012; Nordbo, Espeset, Gulliken, Skarderud, & Holte, 2006; Couturier, 2006). High motivation to change was correlated with shorter duration inpatient treatment and better outcomes, while poor motivation to change was correlated with laxative abuse, depression, body dissatisfaction, and a higher need for hospitalization (Burket & Hodgin, 1993). Also, improved motivation to change during therapy was related to overcoming relapses as they arose. As far as personal characteristics were concerned, a lower BMI was correlated with a lower motivation to change, more full diagnosis, more purging behaviors, lower compliance to dietary recommendations, slower weight gain when applicable, and worse quality of life.

With treatment resistance being highest in anorexics, explanations were presented as to why this may be. The main reason suggested was that AN patients view their behaviors as protecting and stress relieving both physically and psychologically (Skarederud, 2006). Therefore being told to do the opposite, gain weight and eat, can be extremely aversive. For anorexics maintenance of eating disorders can lead to feelings of safety, deflection of threatening emotions, better communication with others, a source of strength, and a means to feel special and in control (Espindola & Blay, 2009). If clinicians cannot find the means to change these mentalities, then the likelihood of relapse can increase.
Treatments

Different treatments have yielded a variety of success rates for different types of eating disorders. For example, cognitive behavioral therapy is typically used to target bulimia (National Institute for Health and Clinical Excellence, 2004; Hay, Bacaltchuk, Stefano & Kashyap, 2009; Shapiro, Berkamn, Brownley, Sedway, Lohr, & Bulik, 2007) as well as binge eating disorder. Effectiveness for the treatment for binge eating disorder is increased when cognitive behavioral therapy is paired with antidepressants (Carlos, Grilo, Masheb & Salant, 2005). Antidepressants can increase recovery rates due to the enhanced state of well-being they provide (Carlos, Grilo, Masheb & Salant, 2005). For women who are considered to be underweight, antidepressants can also help them gain weight as they work towards being an average weight. Anorexia nervosa, compared to other eating disorders, has been the most difficult to treat (Bailey, Parker, Colautti, Hart, Liu, & Hetrick, 2014). A typical approach to anorexia nervosa is family-based therapy (Bailey, Parker, Colautti, Hart, Liu, & Hetrick, 2014). Overall, very few eating disorders are successfully treated. With anorexia nervosa yielding the highest mortality rate (4.0%) among eating disorders, improvements in treatment pathologies need to be designed in the coming years (Crow et al., 2009).

Seeing that the treatment-seeking population is small and the success of treatment in clinics is low for eating disorders, adjustments need to be made to the procedures approaching eating disorder management. As this paper has noted, there are a variety of factors that can contribute to eating disorder etiology. While some of these factors are uncontrollable, others are manageable. Controlling manageable factors and working to address them across cultures could increase the success of treatment. For example, instead of trying to just improve a woman’s weight status, more effort could be put forth in improving body satisfaction in order to decrease body distortion and internalization of the thin ideal. Also improving women’s ability to recognize the thin standard of beauty as more capricious than realistic could help women develop a greater appreciation for a more average body weight. This could be especially beneficial for Anglo-American women. Compared to other disorders, eating disorders may present differently on a more individual basis. Therefore, helping patients address their personal, specific issues would probably yield the greatest improvements in the treatment of eating disorders.

Relapse in Treatment
Relapse has been a significant problem for eating disorder treatments with rates ranging from 22% to 51% across outcome studies (Keel & Mitchell, 1997; Pike, 1998; Russell, 1975; Deter & Herzog, 1994; Strober, Freeman, & Morrell, 1997). Determining predictors of relapse can be difficult; therefore researchers take into account both intake variables and post treatment predictors. With this in mind, more longitudinal studies are being conducted to better understand relapse rates across interventions. Keel, Dorer, Franko, Jackson, and Herzog (2005) conducted interviews with eating disorder patients, biannually for 9 years to gain a better understanding of factors that contributed to relapse in anorexia nervosa and bulimia nervosa.

Interviews were conducted from 1987 to 1996 on 136 bulimia patients and 110 anorexia patients. Beginning with improvements, 75% of patients with an intake diagnosis of bulimia achieved remission while 31% of anorexia patients achieved remission. Of those who achieved remission, 35% whose intake diagnosis was bulimia relapsed, while 36 of those with intake diagnoses of anorexia relapsed. Behaviors that led to relapse for the bulimics included a return to binging and purging. Behaviors that led to relapse for anorexics included purging, demonstrating a change to bulimia nervosa. From interviews, knowledge of predictors of relapse were said to be misperception of body weight and shape, fear of gaining weight or becoming fat, and decreased psychosocial functioning while in treatment.

Overall relapse was seen in both groups with a return and a change to bulimia nervosa. With the main predictors being poor body image and psychosocial stressors, more attention should be turned to regulation of patient’s perceptions during treatment as well as increased education on coping strategies to get through treatment.

One reason success in the treatment for eating disorders may be low is due to there being a delay between onset and treatment. When anorexia or bulimia are engaged in over an extended period of time, they can become intractable to treatment as well as life threatening (Johnson, 1982). Prevention measures for eating disorders are normally secondary or tertiary, but not primary. Secondary prevention is focused on reducing the duration of a disorder through early diagnosis and effective treatment while tertiary prevention is aimed at reducing the impairment of an established disorder (Kessler & Albee, 1975). Seeing that neither situation necessarily shortens the course and severity of eating disorders, maybe more efforts should be put in to primary prevention.
Shisslak, Crago, Neal, and Swain’s (1987) proposition for prevention included the integration of eating disorder education for students of all ages. Aside from including eating disorder education as part of students health, home economics, and physical education curricula in grades Kindergarten through 8th grade; Shisslak and colleagues (1987) suggest helping adolescent women gain the skills to master the tasks of maturation (physiological growth, and psychological changes) and the challenges of upcoming adult life. Essentially Shisslak proposes that women need to be taught that they are in control and that everything around them does not need to control their perceptions of beauty or their eating behaviors. Once in high school, Shisslak then finds it appropriate to address eating disorders specifically, the role of women in society, and the medias portrayal of women. Prevention can also be an area of eating disorder research that could be tailored to specific ethnic groups.

While some environmental, economic, and historic factors may not be manageable, with the proper approach, the sociocultural factors of eating disorders can be managed and reframed to improve the mental health of women (Katz, 1985). Reversing society’s and the media’s proposition of the thin standard could be possible if more women modeled a healthier, realistic weight. If these models included women of a variety of cultures of various body weight and shapes, then it may be possible to get rid of the concept of a single “ideal” weight and shape. Also prevention could play to the protective roles that different ethnicities already present. For example the Latin-American cultural value of familismo could be pushed in order to counteract the negative messages of the media and society. By having Latin-Americans be more concerned with the health of the group and viewing the family as a unit, less concern could be paid to appearance and the expectations from others that women be thin. As for African-Americans, continued promotion of a larger standard of beauty, complimented with nutrition education could help prevent them from disordered eating. Finally helping Anglo-Americans reduce their internalization of the thin ideal and helping them break the connection between thinness and acceptance could greatly improve the mental states and eating behavior of these women. As a individualistic rather than collectivist society, teaching Anglo-American women that all that matters is their own opinion, may be the best approach to reduce eating disorder behavior.

Conclusions

In conclusion multifactorial models involving historical, biological, and sociocultural variables best characterize the etiologies of eating disorders and their core symptoms. How these
diseases manifest in women varies across cultures due to both cultural and individual differences. Seeing that eating disorders in African American and Latin American women are reaching parity with Anglo-American women, new approaches to the diagnosis, management, and treatment of eating disorders need to be made.

In the diagnostic stage new tools need to be designed to be more sensitive to the presentation of eating disorders in different ethnic groups. Reliance of the DSM should be reconsidered, seeing that it is primarily designed by Anglo-Americans for Anglo-Americans (King, 1993). Different standards should be set for different ethnic groups regarding presentation of symptoms and BMI ranges for bulimia, anorexia, and binge eating disorder (Holmqvist & Frisén). Also there needs to be recognition that an ideal or desired figure for one culture may not be the same for another culture.

Biologically recognition of the interaction between food availability, accessibility, and the degree of choice women have needs to be accounted for. Whether or not women have the ability to manage their weight taking into account their economic situation and residency can play a large role in the way they access food and what they have access to (Romero, 2005). Perception of their financial stability as well as the stability of where they live can vary largely and greatly affect how individuals manage their food choices and in turn their body weight and shapes (Dressler & Smith, 2013). While some of these mechanisms may be inherent, such as fat storage or reproductive suppression, some may be acquired. Culture may be the confounding variable in these interactions that could better explain the food choices women make.

The 21st century has thus far presented the greatest concern for eating disorders with society creating and promoting the thin standard (Marian, Fitzgibbon, Blackman & Avellone, 2000). With the media reaching more women of color, Latin Americans have begun to conform to the Anglo-American standard of beauty with African Americans conforming at lower rates. Degree of internalization of the host culture’s standard of beauty could account for these changes (Cashel et al., 2003). With more women of color attending college, and the college environment pushing the thin ideal, higher rates of eating disorders in young adults can occur (Heatherton, Nichols, Mahamedi, & Keel, 1995). With stigmas attached to fatness and thinness as well as different ethnic groups, women of color may be a high risk for personal conflicts between their home and host cultures. An area of research that is working to sort out these differences are studies of acculturation (Castro, Coe, Guiterres, & Saenz, 1996). However more longitudinal
studies need to be conducted to truly determine how women of color’s transition from their home
culture to the host culture affects their perceptions of standards of beauty, and their eating
habits (Rogler, Cortes & Malgady, 1991).

Overall treatment and prevention are areas where there is room for improvement. If
clinicians account for cultural differences in the way they approach Anglo-Americans and
women of color’s relationship with food then it’s possible more women of color would be
diagnosed but also pursue treatment for eating disorders. Barriers may currently be holding
women of color from pursuing treatment or receiving proper treatment (Becker, 2010). By
closing the gap between disorder onset and treatment, the management of eating disorders can be
more efficient (Johnson, 1982). By specifically addressing culture, more could be understood
about how eating disorders affect different women. Culture, may essentially be, the missing
component in understanding eating disorders.
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