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# Eating attitudes among Asian and Hispanic females : comparison between recent immigrants and long-term residents of the United States

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# EATING ATTITUDES AMONG ASIAN AND HISPANIC FEMALES: COMPARISON BETWEEN RECENT IMMIGRANTS AND LONG-TERM RESIDENTS OF THE UNITED STATES

by  
**Katherine Sanchez Ciongoli**©

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Running Head: EATING ATTITUDES IN ASIAN AND HISPANIC WOMEN

Submitted to the Committee on Undergraduate Honors of Baruch College of The City University of New York in partial fulfillment of the requirements for the degree of Bachelor of Arts in Psychology with Honors.

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## **ABSTRACT**

The aim of the present study is to determine the influence of ethnicity and longevity in the United States on the eating attitudes of immigrant women as measured by the Eating Disorders Inventory-2 (EDI; Garner, Olmstead, & Polivy, 1983). Specifically, comparisons are made between college women of Hispanic or Asian backgrounds who have lived in the United States either briefly (under five years) or more extensively (five years or more). The data obtained from the above mentioned condition is compared to the EDI norms for eating disorder patients. Hispanic participants ( $n=24$ ) and Asian participants ( $n=26$ ) were given the EDI-2, a self-report, multiscale (11 subscales) measure designed to assess psychological and behavioral traits common to anorexia nervosa and bulimia nervosa. Statistically significant correlations are found within the Asian group on the following four subscales of the EDI-2: *drive for thinness*, *body dissatisfaction*, *impulse regulation*, and *social insecurity*. In addition, there are statistically significant differences between the scores of the Hispanic and Asian women on both the *perfectionism* and *social insecurity* subscales, respectively. Further research on ethnic issues and their relationship to disordered eating attitudes and behaviors are discussed.

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## **INTRODUCTION**

The incidence of eating disorders, especially among white adolescent females, has risen dramatically over the past two decades. Some researchers have concluded that eating disorders have now reached epidemic proportions, at least in Western society (Shisslak, Crago, Neal, & Swain, 1987).

Historically, minority women in Western society have had a lower incidence of eating disorders than have white females. However, this trend appears to be changing. Tomas Silber (1986; as cited in Thompson, 1992) asserts that many clinicians often either misdiagnose or delay their diagnoses of eating disorders among minority women because they incorrectly believe that these problems are restricted to white women. He further argues that when diagnosed in minority patients eating disorders tend to be more severe. It has been suggested that this may be due to a later diagnosis because of assumptions that eating disorders are nonexistent among ethnic minorities. In addition, cultural values regarding trust and openness with strangers may prevent certain ethnic groups from seeking psychological intervention outside of their intimate social and familial network. Consequently, minority women who are underserved may have a higher incidence of eating disorders than reported.

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## **TYPES OF EATING DISORDERS**

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; 1994), a diagnostic guide for mental health professionals, lists the various types of eating disorders and the factors which may lead to the development of these disorders. In order to receive a formal psychiatric diagnosis, a patient must have sufficient symptomatology to fulfill a specific diagnostic category. Thus, this diagnostic manual enables clinicians to be reasonably secure when diagnosing a patient. The DSM-IV describes the two major eating disorder categories--anorexia nervosa and bulimia nervosa-- as follows:

### **a: Anorexia Nervosa**

The primary features of anorexia nervosa are extreme weight loss, profound fear of weight gain, and a significant distortion in the perception of body size. Anorexia nervosa typically begins during adolescence with at least 90% of cases occurring in females. Weight loss, which can be life threatening, is accomplished primarily through dieting, fasting, and excessive exercise. In some cases, purgative behaviors such as self-induced vomiting, and the abuse of laxatives, diuretics, and enemas are used by the anorectic in order to achieve weight loss. This behavior is driven by the anorectic's extreme fear of weight gain, perceived body size distortion, and a preference for thinness (Williamson, 1990, p. 25).

The anorectic's' intense fear of becoming fat is not typically alleviated by weight loss. On the contrary, the more weight the anorectic loses the more this obsession intensifies. Although some anorectics feel that they are overweight, others realize that they are thin but are overly concerned with certain parts of their bodies. Anorectics, as well as bulimics, tend to perceive their abdomens, buttocks, and thighs as being "too fat." The self esteem of individuals with anorexia nervosa is highly dependent on their weight and body shape (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994, p. 540).

According to the DSM-IV, "weight loss is viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self control" (American Psychiatric Association: Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, 1994, p.540). However, most anorectics are obsessed with thoughts of food. Many anorectics collect recipes and are usually responsible for the preparation of meals within their households. Furthermore, the DSM-IV (1994, p. 541) states that behaviors associated with other forms of starvation suggest that obsessions related to food and eating may be precipitated or heightened by undernutrition.

The physical consequences of severe weight loss include cessation of the menstrual cycle (amenorrhea), which is due to abnormally low levels of estrogen secretion, hair loss, lowered body temperature, and dry skin due to dehydration. Some individuals develop lanugo, a fine downy body hair on their bodies. Semistarvation and purging behaviors are sometimes associated with anemia, impaired renal function, and cardiovascular problem which when untreated can lead to death (Zerbe, 1993, pp. 254-259).

The DSM-IV (1994), classifies anorexia nervosa into two distinct subtypes:

**Restricting Type.** This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise. During the current episode, individuals do not regularly engage in binge eating or purging.

**Binge-Eating/Purging Type.** This subtype is used when the individual has regularly engaged in binge eating or purging (or both) during the current episode. Most individuals with Anorexia Nervosa who binge eat also purge through self-induced vomiting, or the misuse of laxatives, diuretics, or enemas. Some individuals included in this subtype do not binge eat, but do regularly purge after the consumption of small amounts of food. It appears that most individuals with Binge-Eating/Purging Type engage in these behaviors at least weekly, but sufficient information is not available to justify the speculation of a minimum frequency" (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994, p. 541).

Donald A. Williamson (1990) argues that the core psychopathology of anorexia nervosa, such as body image disturbances and fear of fatness, usually develop after an individual has begun using extreme methods of weight control, such as avoidance of eating. The physiological consequences of dietary restraint are energy deprivation and hunger. Most

individuals under these physiological conditions break dietary restraint by bingeing or overeating which in turn strengthens fears of weight gain. In the anorectic, this fear becomes more intense and the consumption of large quantities of food are avoided, thus reducing the anxiety associated with bingeing. As the disorder progresses, the anorectic experiences a suppression of appetite which strengthens the individuals ability to maintain dietary restraint and avoid the anxiety associated with weight gain.

## **b: Bulimia Nervosa**

The principal characteristic of bulimia nervosa is a binge-purge pattern, in which the bulimic feels an overwhelming urge to binge, (the consumption of large amounts of food in a short period of time) and then an equally overwhelming urge to purge (eliminate) from the body any foods that were eaten during the binge. Researchers report that many bulimics are college students in their late teens or early twenties, but that they range in age from 17 to 51, with a mean age of 24.3 years (Bilich, 1989). In addition, "in clinic and population samples, at least 90% of individuals with bulimia nervosa are female" (American Psychiatric Association: Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, 1994).

Individuals with bulimia nervosa are ashamed of their behavior, hence, bingeing usually occurs in secrecy. During the purging stage of the illness the bulimic uses inappropriate compensatory behaviors in order to avoid weight gain. The most common form of purging behavior is self-induced vomiting. This method of compensatory behavior is used by 80%-90% of individuals with bulimia nervosa (American Psychiatric Association: Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, 1994, p. 546). Other less common methods of purging include the chewing and spitting out of unswallowed food, and the misuse of laxatives, diuretics, enemas, and diet pills.

According to the DSM-IV, "binge eating is typically triggered by dysphoric mood states, interpersonal stressors, intense hunger following dietary restraint, or feelings related to body weight, body shape, and food" (American Psychiatric Association: Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, 1994, p. 546). The underlying factors which drive the purgative behavior of bulimia nervosa are similar to those of anorexia nervosa, including body image disturbances, intense fear of weight gain, and an extreme preoccupation with body shape and size. Furthermore, Dickstein (1989, p. 111) describes the prototypical bulimic woman as being preoccupied with food, dieting, and eating, especially in response to feeling depressed or anxious, and less so when actually hungry.

Johnson and Connors (1987; as cited in Bilich 1989, p.18) concluded that 70% of individuals with bulimia nervosa were of normal weight (as determined by the Metropolitan life Insurance Company tables), while 15 % would be considered underweight, and 15% overweight. Although many bulimics believe that they are overweight, Johnson and Connors's data indicates that a high percentage of bulimics are of normal weight.

Bulimia nervosa has medical consequences that can be devastating and even fatal (with an estimated mortality of 10%-15%). Some of the medical complications that can result from frequent purging behavior include metabolic imbalances, gastrointestinal complications (esophagitis), cardiac dysfunction, and the erosion of dental enamel. In addition, fluid and electrolyte disturbances are sometimes severe enough to cause serious medical complications (Zerbe, 1993, pp. 260-265).

The DSM-IV (1994), classifies bulimia nervosa into two distinct subtypes:

**Purging Type.** This subtype describes presentations in which the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas during the current episode.

**Nonpurging Type.** This subtype describes presentations in which the person has used other inappropriate compensatory behaviors, such as fasting, or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas during the current episode (American Psychiatric Association: Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, 1989, p. 547).

According to Donald A. Williamson, the core psychopathology of bulimia nervosa, such as overconcern with body size and fear of weight gain, usually precede extreme weight control methods such as purging (Fairborn & Cooper, 1982; as cited in Williamson, 1990). Like anorexia nervosa, the physiological consequences of dietary restraint in bulimia nervosa are energy deprivation and hunger. Once dietary restraint is broken, bingeing or the consumption of forbidden foods are likely to produce increasing anxiety and worry concerning weight gain. Overeating activates fears of weight gain and body image disturbances which also increase anxiety and worry. This purging behavior serves the function of alleviating the intense feelings of anxiety and worry experienced by the bulimic following a bingeing episode. A direct result of the binge-purge cycle is a lowered basal metabolic rate which in the long-term increases the probability of weight gain. When eating results in weight gain the bulimic's fear of fat is strengthened and purgative behaviors increase in frequency and severity (Williamson, 1990).

However, it should be noted that there is high incidence of weight problems in the family members of bulimics. Therefore, familial obesity may be considered as a possible risk factor in the development of bulimia nervosa. Strober and Humphrey (1987) hypothesized that the "association between bulimia and parental obesity suggests that there may be a greater constitutional resistance to weight loss in certain individuals that is causally related to binge eating under conditions of nutrient deprivation" (1987, p. 662). Familial involvement in the development of eating disorders comes from evidence that such disorders occur more frequently in the biological relatives of eating disorder patients. Current data put the lifetime expectancy of bulimia at approximately 2% (Cooper & Fairbum, 1983; Crisp, Palmer, & Kalucy, 1976; Gershon et al., 1983; as cited in Strober & Humphrey, 1987, p. 656). Nevertheless, Bilich (1989, p. 19) argues that in attempting to understand familial obesity as a risk factor, one is faced with the task of separating genetic factors from purely environmental ones.

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## **EATING DISORDER INVENTORIES**

In the past two decades, researchers have developed two different types of predictive tests for eating disorders: the Eating Attitudes Test (EAT) and the Eating Disorders Inventory (EDI).

The EAT, a 40-item self-rating scale was developed by Garner and Garfinkel (1979; as cited in Williamson, 1990, p. 37) to assess anorexic and bulimic attitudes regarding eating. The EAT has been used as a screening instrument for detecting cases of anorexia nervosa and bulimia in groups at high risk for these disorders, as well as identifying abnormal eating patterns among college students.

The Eating Disorders Inventory (EDI; Garner, Olmstead, & Polivy, 1983), is a widely used 64 item self-report, multiscale measure designed to measure psychological and behavioral traits common to anorexia nervosa and bulimia nervosa. The measure evaluates individuals on a number of different subscales including *drive for thinness*, *bulimia*, *body dissatisfaction*, *ineffectiveness*, *perfectionism*, *interpersonal distrust*, and *maturity fears*. The first three subscales (*drive for thinness*, *bulimia*, and *body dissatisfaction*) assess attitudes and behaviors related to eating disorders. The remaining five subscales (*ineffectiveness*, *perfectionism*, *interpersonal distrust*, and *maturity fears*) measure personality traits which have been identified as fundamental aspects of the psychopathology of anorexia nervosa. Garner et al. found that in assessing personality traits on the EDI:

[t]he *[i]neffectiveness* subscale was most highly correlated with feelings of inadequacy, depression, and external locus of control; *[p]erfectionism* with a measure of interpersonal sensitivity; *[i]nterpersonal [d]istrust* with low self-esteem and depression (Garner et al., 1983, p. 31).

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## **ETIOLOGY OF EATING DISORDERS**

Until recently, clinical and research literature have emphasized unidimensional models of causation to account for eating disorders. Earlier explanations of the origins of eating disorders typically fit into one of three unidimensional models: the biomedical, the psychological, or the sociocultural. However, no unidimensional theory (i.e., eating disorders as resulting from: depression, neurological dysfunction, developmental failures and traumas, or as a sociocultural phenomenon) has been able to account for the variations and complexities associated with these disorders.

Eating disorders are clearly multidetermined disorders that depend on the individual's biological vulnerability (including genetic and physiological components), psychological predisposition (including early experiences and personality conflicts), family environment and social climate (Garner & Garfinkel, 1982; Lucas, 1981; as cited in Brumberg, 1989, p. 24). As a result, Schwartz, Thompson, and Johnson (1982; as cited in Bilich, 1989, p. 14) have proposed a multirisk factor model to explain the complexity of eating disorder symptomology. According to this model, it is the interaction of several elements such as, sociocultural, familial, and personality factors, which lead to the development of disordered eating patterns (Schwartz et al., 1982; as cited in Bilich, 1989, p. 14). The following discussion will focus on the various components of the multirisk factor model in the development of eating disorders.

### **a: Sociocultural Influences**

The sociocultural explanation of eating disorders appears to be an appropriate starting point since it is a popular and widely promoted component of the multirisk factors model. Industrialized society's emphasis on thinness, especially for females, is generally thought by many researchers to be a major factor in the appreciable increase of anorexia nervosa and bulimia in young women. The cultural explanation of eating disorders postulates that these disorders are generated by powerful cultural forces that make thinness the major attribute of feminine beauty. In modern Western societies young women readily attach themselves to dieting primarily because it is a widely practiced and admired form of cultural expression (Brumberg, 1988, p. 31).

Researchers have estimated that over 60 percent of U.S. women are dieting at any point during a year, and that number seems to be going up (Meadow & Weiss, 1992, p. 25). Dieting and thinness began to be female preoccupations for Western women in the 1920s when the "basic institutions of beauty culture were formulated: the fashion and cosmetic industries; beauty contests; the modeling profession; and the movies" (Zeldin, 1977; as cited in Bruinberg, 1988).

In the 1920s, many women aspired to a slim body because such a body was not only fashionable, but it also made a statement about the major social and political changes women were experiencing. During this period, American women experienced something of a revolution, not only were they given a political voice--the vote--but an increasing number of women were working outside of the home. "A woman with a slender body distinguished herself from the plump Victorian matron and her old-fashioned ideals of nurturance, service, and self-sacrifice" (Brumberg, 1988, p. 245). In addition, as early as the 1920s, consumer culture was promoting weight control in popular magazines hoping to sell products to young women. The image of the rail-thin flapper on the pages of fashion magazines promoted the idea that thinness was a crucial dimension of female beauty.

The thin-body ideal has retained its appeal throughout the twentieth-century, particularly for adolescent girls, but beginning in the 1960s, signaled by the invasion of bone-thin models like Twiggy, the standard of fashion has become ever more rigid in the direction

of "skeletal" thinness (Gordon, 1989, p. 44). An often cited example of the increasing idealization of thinness was demonstrated in a study of the body shape of Playboy centerfolds from the years 1960 to 1980 (Garner, Garfinkel, Schwartz, & Thompson, 1980; as cited in Gordon, 1989) that showed that the weight of the "Playmate of the Month" decreased from 91 percent of average weight in the 1960s to 83 percent of average in the late 1970s. In addition, in the *Body Betrayed* (1993), Kathryn Zerbe notes that in 1968, the average fashion model was 8 percent thinner than the average woman. Today, models are 23 percent thinner, conveying unrealistic ideals of beauty and femininity.

The diet industry in America during the twentieth-century has expanded into a highly lucrative capitalist enterprise. Meadow and Weiss note that:

more than \$10 billion a year are spent on diet drugs, diet meals, diet books, exercise tapes, weight-loss classes, and fat farms. Approximately \$800 million goes for frozen diet dinners, and another \$200 million goes for diet pills. In addition, hundreds of millions of dollars are spent on diet books, health club memberships, and exercise videotapes (Meadow & Weiss, 1992, p. 25).

The bitter reality that most people who diet gain back more than they lose is eclipsed by an advertising industry which profits enormously: \$285 million for TV, newspaper, and magazine advertisements in 1987 alone. In addition, many fashionable women's magazines are filled with diet articles, "...between 1980 and 1984 there was an average of 1.25 dieting articles per issue in *Ladies Home Journal*, *Good Housekeeping*, and *Harper's Bazaar*; 66 articles on dieting appeared in 22 contemporary magazines in January of 1980 alone" (Gutwill, 1994, pp., 32-33).

Commercial images provide powerful models for social comparison. The increase in eating disorders is blamed in part on media images in which an ultra-thin female body-type predominates, and positive social qualities are linked to being thin. Obviously, American culture has little tolerance for female fat, being overweight has very negative interpersonal implications. Women struggle with their appetites and their bodies because a woman's measure of femininity and attractiveness plays such a central role in her identity and self-esteem.

The absence of weight control, especially in women, can lead to social discrimination, isolation, and low self-esteem.

The most prominent feature [of "weightism,"] is a deep-rooted but unfounded belief that overweight people, and in particular overweight women, are ugly, lazy, sloppy, weak, incapable, masochistic, and in need of therapy for their complete lack of self control (Garner, Rockert, et al., 1985; Steiner-Adair, 1987; Wooley & Wooley, 1982; as cited in Clark, Levine, & Kinney, 1989, p. 267).

Contemporary Western society has essentially rejected the image of the traditional, nurturing woman. However, this view of feminine beauty is not shared universally. Many

cultures see ample figures as highly sexual and exotic. Viewed in this light obesity is not inherently ugly, but only a reflection of what is deemed attractive in contemporary Western culture (Meadow & Weiss, 1992).

Researchers have suggested that athletes involved in sports that require leanness (e.g., ballet, figure skating, swimming, and gymnastics) may be especially susceptible to the sociocultural pressures-to achieve a slim body shape. Several studies have shown that "as many as 25% of participants in these sports actually have an eating disorder" (Zerbe, 1993, p. 139). In a study of the prevalence of anorexia-like symptoms in a group of 49 female ballet students between the ages of 16 and 29, le Grange, Tibbs, and Noakes (1994), documented the presence of anorexia nervosa in 4.1% of the participants. In addition, another 8.2 % partial syndrome cases of anorexia nervosa were identified. The results of the study also showed that a significant proportion of students who did not qualify for a diagnosis of anorexia nervosa presented with abnormal eating attitudes, excessive concern about weight and shape, low weight, and menstrual abnormalities.

Susan Gutwill (1994) argues that the culture of exercise further contributes to America's fat phobia and its culturally determined attitudes about thinness in women. Women of all ages and backgrounds are constantly reminded to "get in shape" by the large number of books, records, and videotapes available in almost any local store. Furthermore, magazine articles constantly stress the importance of having the perfect body. Their titles-- as in two articles in the June 1985 issue of *Mademoiselle*-- "How to Make Your Body Bare-able," and "Legs are Back! Can You Bare Them?", remind women of their imperfections and create guilt about not meeting standards of thinness (Meadow & Weiss, 1992, p. 33). Susan Gutwill argues that all women, regardless of their ethnic, racial, social, or feminist affiliation, must reckon with the "visual, advertising-based images of the ideal woman" (1994, p. 24). Moreover, advertised thinness promises that women can "have it all"--look like a woman and succeed like a man--however, its most powerful secret message is to remind them that despite "having it all," women are still judged on the basis of their bodies.

The cultural image of the ideal female or the "superwoman," who "has it all," is most often associated with a tall thin body, a briefcase and a high-level of achievement (Adair-Steiner, 1989, p. 157). The significant shifts in the female social role that have been in evidence since the 1960s have had a dramatic impact on feminine identity. Pivotal changes in social attitudes, due to the emergence of contemporary feminism, have afforded women access to higher education and achievement-oriented careers. They no longer fit into the singular role of the dependent, self-sacrificing woman of the past. Instead, women have attempted to integrate into their identities the roles of the devoted wife, the nurturing mother, and the high-powered career woman. However, many women are ill-prepared to meet the contradictory ideals placed on them by modern society. "From a feminist perspective, eating disorders are an attempt to negotiate paradoxical social demands of femininity" (Wurman, 1989, p. 168).

On the one hand, Western women are expected to be independent, ambitious, and successful, while on the other, they must fulfill the traditional expectations for a nurturing

social role, in which one remains dependent and oriented towards the needs of others (Gordon, 1989, p. 47). Accordingly, for a number of women these shifts in social ideals have led to significant confusion and conflicts in identity (Bardwick, 1979; as cited in Gordon, 1989).

It has been suggested that women with a strong commitment to fulfilling traditional feminine gender roles, such as a focus on physical attractiveness and an orientation toward nurturance, will experience significant levels of stress when faced with the challenges of meeting the ideals of the "superwoman." Martz, Handley, and Eisler (1995, p. 494), for example, found that women who have eating disorders report high levels of stress as a result of a rigid commitment to the traditional feminine gender role. Moreover, Martz et al. (1995, p. 493) suggest that "feminine gender role stress may be the missing link" between cultural ideals of femininity and vulnerability for eating disorders. There is some evidence that women with eating disorders, specifically bulimics, are particularly prone to adopt the media ideal of the "superwoman." Research done by Steiner-Adair (1985; as cited in Gordon, 1989) on high school students found that those who were most drawn to the "superwoman" stereotype had the highest scores on the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979; as cited in Gordon, 1989), a measure used to assess anorexic attitudes regarding eating.

The current idealized female form--tall, narrow-hipped, and thin thighed--is a body-type that is biogenetically difficult to achieve and maintain. According to the set point (or body weight) theory, a physiologically based model, individuals have a predetermined weight that their bodies will work vigorously to maintain. It is generally thought that heredity determines an individual's initial set point. The natural set point may or may not be set at the weight level desired by the individual. However, overeating can reset an individual's set point at a higher weight level. Research (Sjostrom, 1980; as cited in Williamson, 1990) has shown that once excess adipose cells are created they can not be removed. If an individual, with a set point reset at a high weight level chronically takes in more energy than is expended, they will continue to gain weight and find it difficult to maintain lower weight levels (Williamson, 1990, p. 3).

America's preoccupation with thinness has been commented on by Bruch (1973) and others in explaining the etiology of anorexia nervosa. These standards of physical attractiveness are also explicative of the negative attitudes toward obesity (Wolman, 1982). Bruch argues that although anorexia nervosa deserves to be defined as a special syndrome, it can also be conceived of as a counterpart to obesity. Preoccupied as these patients are with eating or not eating they may have in common the inability to identify hunger correctly or to distinguish it from other bodily needs (Bruch, 1973, p. 4). Thus, the belief that overweight people have "no willpower" may actually be a description of their not being able to control that which is not even recognized. In addition, Pike (1995) reports that the link between disordered eating and a lack of interoceptive awareness indicates that disordered eating is associated with difficulties in identifying internal body states.

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## **EATING DISORDERS IN AMERICAN ETHNIC GROUPS**

Western societal standards for beauty, which emphasize a thin-body ideal for women, may be rapidly influencing the values and lifestyles of women whose sociocultural values have traditionally precluded the emergence of eating disorders. In the past, according to the normative epidemiological portrait, eating disorders have principally been recognized as a white, middle-, and upper-class phenomenon (Thompson, 1992, p. 546). However, it appears that the prevalence of these disorders may be increasing dramatically among ethnic minority women in the United States (Pate, Pumariega, Hester, & Garner, 1992, p. 802).

Several authors (e.g., Garner et al., 1983; Nasser, 1988; as cited in Pate et al., p. 802) have suggested that the rise in the prevalence of eating disorders among ethnic minority women may be due to a wider identification of the ideal that thinness has come to symbolize in Western culture. The ideal of thinness being symbolic of sexual liberation, assertiveness, competitiveness, and affiliation with a higher socioeconomic class, as well as a measure of feminine beauty.

It is clear that the Western obsession with the ideal of thinness pushes women to conform to a societal ideal of weight and shape (Dolan, 1991). Immigrants from countries for which eating disorders are rare who emigrate to countries with a high incidence of anorexia and bulimia nervosa may develop any one of these disorders, as thin-body ideals are assimilated (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994, p. 543).

Pumariega (1986; as cited in Pate et al., 1992) investigated the link between acculturation and eating attitudes in white and Hispanic adolescent girls between the ages of 16 and 18. He compared the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979; as cited in Pumariega, 1986) scores of Hispanic subjects to those of a group of white subjects. Although the two groups had similar scores on the EAT, Pumariega found that there was a significant positive correlation between levels of acculturation and EAT scores in the Hispanic group. He concluded that the results supported the hypothesis that cultural influences are related to a higher incidence of eating disorders. He suggested that a strong adherence to Western culture may increase an individual's susceptibility toward the development of eating disorders.

Two case studies of eating disorders in East European immigrants have highlighted the influence of acculturation on young women. Bulik (1987) describes two female Russian emigres to America, who developed an eating disorder within two years of immigration. He suggests that "attempts to adapt to a new culture can lead to an exaggerated overidentification with aspects of that culture, in this case an overvaluation of slimness as desirable" (Bulik, 1987; as cited in Dolan, 1991, p. 73).

Very little has been noted about the prevalence of eating disorders in Asian-Americans. Early studies do not indicate that Asians were studied as a distinct ethnic group. In the United States, the first two citations of nonwhite anorectics appeared in a study on 42 patients seen between 1960-1971 in New York (Warren & Vande Wiele, 1973; as cited in Dolan, 1991). One was Chinese and the other African-American, but no further details were given regarding ethnicity and its effect on the development of the disorder. In another New York study, Silverman (1977; as cited in Dolan 1991) reported one Asian woman among 65 anorectic patients admitted to his unit over the previous decade.

In one of the few studies focusing on eating disorder patients from different ethnic groups within the United States, Silber (1986; as cited in Pate et al., 1992) studied seven minority adolescents with anorexia nervosa, including five Hispanics and two African-Americans enrolled in a predominantly Caucasian school. These women were described as disappointed by what they considered their "big" bodies. Silber concluded that the process of acculturation (to a white, middle-class culture) in American ethnic minority women who had developed an eating disorder was critical because these individuals, who "were already feeling different and suffering from a low self-esteem and a powerful need to be accepted, sought integration with society through rigid dieting and an extreme adoption of the current social standard of slimness" (Silber, 1986; as cited in Pate et al., p. 803).

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## **EATING DISORDERS ABROAD**

Eating disorders have been spreading to other industrialized nations outside of the United States. Larger patient groups have been reported in Western Europe and Japan as well as in the United Kingdom where there are 3.5 million anorectics or bulimics (95 percent of them female), with 6,000 new cases yearly (Wolf, 1991, p., 183).

In the past two decades, Western standards of beauty have greatly affected Japan, where eating disorders are now well recognized and on the increase. A survey of Japanese medical institutions documented 1,011 patients with anorexia nervosa between 1980 and 1981 (Dolan, 1991, p.70). As a result, eating disorder clinics have been established in many urban Japanese hospitals (Zerbe, 1993).

A British study (Whitehouse and Mumford, 1988; as cited in Dolan, 1991, p. 69) However, it has been introduced in order to include as much existing data as possible regarding ethnic groups and eating disorders. In the study of 204 Asian and 355 Caucasian schoolgirls, Whitehouse and Mumford found that the mean Eating Attitudes Test score of the Asian participants was significantly higher than that of the Caucasian group. Interestingly, they concluded that the girls who described themselves as being from more traditional families were at a higher risk for developing an eating disorder than

those who described themselves as being from more Westernized families (Mumford, 1988, personal communication; as cited in Dolan, 1991, p. 69).

In a study done in Kenya, Furnham and Alibhai (1983; as cited in Pate et al., 1992) compared the differences in the perception of female body shapes in subjects of Kenyan Asian ancestry, Kenyan British ancestry, and British immigrants to assess cross-cultural differences in the perception of female body types. They found that the Kenyan Asians perceived thin female shapes more negatively and fat shapes more positively than did the British group. They also noted that the British Kenyans had perceptions that tended to be similar to those of the British group. The researchers concluded that the positive valuing of thinness is a sociocultural phenomenon and that perception of body shape is heavily influenced by cultural factors.

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## **FAMILY DYNAMICS**

According to the multirisk factor model, sociocultural elements alone cannot explain the rapid increase in eating disorders. Familial influences must be examined in order to gain a comprehensive understanding of the complexities underlying the development and maintenance of eating disorders. During the past decade a great deal of attention has been paid to the values and patterns of interaction within the families of eating disordered patients. Studies have suggested that dysfunctional family relationships are frequently associated with the development and endurance of eating disorders.

### **a: Family Interaction and Anorexia Nervosa**

An important theoretical perspective on anorexia nervosa was proposed by family-systems theorist, Salvador Minuchin, who suggested that "certain kinds of family environments encourage passive methods of defiance (such as not eating) and make it difficult for individuals to assert their individuality" (Brumberg, 1988, p. 29). Minuchin, Rosman, and Baker (1978; as cited in Strober & Humphrey, 1987, p. 654) identified five patterns of impaired interaction which they believed lay at the core of the psychopathologies associated with anorexia nervosa: enmeshment, overprotectiveness, rigidity, conflict avoidance, and poor conflict resolution. They described the anorectic as "enmeshed," meaning that the process of individuation is obstructed by the complicated psychological needs of the patient and the patient's family.

It has been suggested that the mothers of restricting anorectics (anorectics without a history of bulimia) are "intrusive, overprotective, anxious, perfectionistic, and fearful of separating from their children; fathers were commonly described as emotionally constricted, obsessional, moody, withdrawn, passive, and ineffectual" (Strober & Humphrey, 1987, p. 654). However, it is usually the mother who is implicated in anorexia nervosa. In a study of 71 Asian schoolgirls and 115 Caucasian girls, Ahmad,

Waller, and Verduyn (1994) found that Asian girls living in the United Kingdom had more unhealthy eating attitudes than Caucasian girls. They suggested that the difference in eating attitudes between Asian and Caucasian girls may be related to perceived maternal overprotectiveness. They further suggest that the findings may have important implications for clinical work with Asian females.

Kim Chernin (1985), a psychoanalytically inspired feminist writer, argues that eating disorders are based on problems of mother-daughter separation and identity. She writes that modern daughters experience the "hunger knot," which represents issues of arrested female development, fear, and the daughter's guilt over her yearning to surpass her mother. "The contrast for most women between their life of possibility and their mother's life of limitations continues to haunt them through every stage of growth and development, making separation a perilous matter..."(Chernin, 1985, pp. 57-58). Both psychodynamic and family-systems theorists agree that the anorectic is one who has difficulty separating from the family and forming an autonomous identity.

A number of researchers, including Hilde Bruch (1973, 1978), have reported that maternal overinvolvement may lead to anorexia nervosa. The developmental task faced by all women is to achieve separateness and individuality while maintaining the mother-daughter bond. Yet, the task proves to be elusive for the anorectic who experiences her mother as too close and overwhelming. According to Selvini-Palazzoli (1978; as cited in Zerbe, 1993), the more a young girl matures and begins to develop a womanly body, the more she experiences herself as exactly like her mother. This experience may be devastating for some young women who may begin to starve themselves in an desperate attempt to achieve individuality. In the *Golden Cage* (1978), Hilde Bruch writes that many anorectics live their lives trying to meet the expectations of their families. According to Bruch, the anorectic often believes that it is her responsibility to make her parents feel good, successful, and superior. She further states that "a common feature is that the future patient was not seen or acknowledged as an individual in her own right, but was valued mainly as someone who would make the life and experiences of the parents more satisfying and complete" (Bruch, 1978, p. 36).

## **b: Family Interaction and Bulimia Nervosa**

The family environment of bulimic patients can be characterized as disengaged, chaotic, highly conflicted and neglectful (e.g., Johnson & Finch, 1985; Palazzoli, 1974; as cited in Johnson et al., 1989). Several studies have used self-report measures to compare perceived family relationships among the bulimic's family members with those of normal control subjects. Johnson and Flach (1985; as cited in Strober & Humphrey, 1987) found replicable differences between normal weight bulimics (without a history of anorexia nervosa), and normal control subjects on the Family Environment Scale, (FES; Moos & Moos, 1980; as cited in Strober & Humphrey, 1987). They concluded that bulimics perceive their families as being less cohesive, expressive, and active in recreation and as more conflictual and disengaged than normal control subjects.

Bulimia has been strongly associated with a lack of parental affection. Humphrey (1986; as cited in Strober & Humphrey, 1987,) has reported on a series of studies that suggest that as the bulimic craves food, so do she and her family crave nurturance and affection from one another. Despite seeking more nurturance from their parents, bulimics often feel that their parents, specifically their mothers, are unavailable both emotionally and physically. Researchers have suggested that when the mother is unable to adequately fulfill the maternal role the child will turn to food as a source of nurturance. Kathryn Zerbe (1993), argues that "food not only symbolizes mother by it's feeding function, but it also has the power to soothe" (Zerbe, 1993, p. 65). Bloom and Kogel (1994) further assert that food, feeding, caretaking, and the caretaker are inextricably interwoven from the beginning, and that when there are problems in the parent-child relationship, there will inevitably be problems in the way feeding and food are perceived by the child.

In a more recent study, Pike (1995) suggests that there is a positive association between bulimic symptomatology and dissatisfaction with family cohesion. Pike argues that as the level of bulimic symptomatology increases, so does the gap between the bulimics' perception of current family cohesiveness and her ideal. She further asserts that individuals who develop bulimic symptoms may do so because they lack or are unable to use appropriate coping strategies to deal with their feelings of alienation and loneliness. Furthermore, she writes that "a family that is not cohesively organized may both lead to and allow for the disorganization and secrecy typical of disordered eating" (Pike, 1995, p. 386).

### **c: Family Interaction and Eating Disorder Subtypes**

According to series of studies comparing the three subtypes of eating disorders (restricting anorexia nervosa, anorexia nervosa with bulimia nervosa, and bulimia nervosa in normal weight individuals) to one another and to normal control subjects, Humphrey (1986a, 1986b, 1986c; as cited in Strober & Humphrey, 1987) found that all three clinical subgroups tended to perceive their familial relationships as more blaming, rejecting, and neglectful relative to normal control subjects. However, the two bulimic subgroups also experienced a deficit in parental nurturance and emotional involvement. Compared with the families of the bulimic subgroups, the families of restricting anorectics more frequently conveyed opposing messages of affection and caring along with enmeshment and negation of the child's needs (Strober & Humphrey, 1987, p. 656).

In a related study, Shisslak, McKeon, & Crago (1990), used three assessment instruments including: the Family Environments Scale (Strober, 1981; as cited in Shisslak et al., 1990), the Family Dynamics Survey (Berren & Shisslak, 1980; as cited in Shisslak et al., 1990), and the Eating Attitudes Test (Garner & Garfinkel, 1979; as Cited in Shisslak et al., 1990) to provided strong support for the hypothesis that bulimics and bulimic anorectics (bulimics with a history of anorexia nervosa), perceive their families as significantly more dysfunctional than do normal control subjects. In addition, Humphrey, Apple, and Kirschenbaum (1986), compared the families of bulimic anorectics with normal control families using the Structural Analysis of Social Behavior model (SASB; Benjamin, 1974; as cited in Humphrey et al., 1986). Their findings were consistent with

those from a parallel rating scale, which indicated that the families of bulimic anorectics were more belittling and neglectful when compared to normal control subjects and were less helpful, trusting, and nurturing toward each other.

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## **PERSONALITY DETERMINANTS**

The multirisk factor model proposes that the interaction of many factors, including certain personality traits, may lead to the development of disordered eating patterns and behaviors. Recently researchers (e.g., Garner et al. 1983) have recognized several personality traits as possible predisposing factors in the development and maintenance of eating disorders. Garner et al. (1983) have based part of the Eating Disorders Inventory on the assumption that certain personality traits increase an individual's risk for developing an eating disorder. However, other researchers have stressed the heterogeneity of eating disorder patients, and have argued that there is no universal personality pattern in either anorexia nervosa or bulimia (Bram, Eger, & Halmi, 1982; Swift & Stern, 1982; Yager & Strober, 1985; as cited in Shisslak et al., 1987).

### **a: Personality Determinants and Anorexia Nervosa**

Anorectics have often been described as introverted, compliant, perfectionistic, dependent, stubborn, and unresponsive to inner needs (Bemis, 1978; Garfinkel, & Garner, 1982; as cited in Shisslak et al., 1987). In addition, they have been characterized as being overly submissive, deficient in their sense of autonomy, and lacking in self-assertion.

Crisp (1965, 1980; as cited in Garner, Olmstead, & Polivy, 1983) and Bruch (1973, 1978) both stress that anorectics wish to retreat to the security of the preadolescent years because of maturity fears and the demands of adulthood. Bruch argues that "[n]ormal development and [bodily] changes are interpreted as 'fatness.' Whatever the outward criticism of the body, the deeper anxiety is that, with adult Size, more independent behavior is expected" (Bruch, 1978, p. 65) The typical onset of anorexia nervosa during adolescence, suggests that the anorectic may be attempting to halt the normal course of maturation. The very nature of anorexia nervosa (emaciation) results in a very public exposure of the individuals severely restricted physical development, eating behavior, and psychosocial functioning.

### **b: Personality Determinants and Bulimia Nervosa**

On the other hand, bulimics have been described as "more extroverted and more active interpersonally and sexually than anorectics" (Johnson, 1982; as cited in Shisslak et al., 1987, p. 661). However, bulimics tend to have interoceptive difficulties (difficulties identifying internal states) which contribute to low self-esteem and feelings of ineffectiveness (Johnson et al., 1989). In a study of 400 high school girls, Pike (1995, p.

388) found that a sense of ineffectiveness and low interoceptive awareness were positively associated with an increase in bulimic symptomatology. Pike further argues that a bulimic individual's feelings of ineffectiveness may lead to bingeing behavior as a means of coping with anxiety and discomfort. In a related study, Swain, Shisslak, and Crago (1991, p. 706) found that measures of control were related to bingeing and vomiting. They hypothesized that the experience of not being in control may undermine the bulimic individuals confidence in her ability to cope and may strengthen her reliance on inappropriate coping methods.

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## **DUAL DIAGNOSES**

Although anorexia nervosa and bulimia "were once believed to be relatively simple problems of eating, mental health professionals are currently recognizing that these disorders are often the mere tip of an iceberg of other psychological disturbances" (Zerbe, 1993, p. 27). Eating disorders have frequently been associated with depression, personality disorders, and substance abuse. Williamson (1990) argues that the secondary psychopathology of eating disorders (e.g., depression, personality disorders, and substance abuse) is often thought to interact in a bilateral manner with the core psychopathology (e.g., avoidance of eating and/or bingeing and purging) of these disorders. This interaction is viewed as bidirectional, as the secondary problems worsen, so should the core psychopathology.

### **a: Bulimia Nervosa and Depression**

Clinical studies of depression and bulimia nervosa have consistently linked the two conditions. Zerbe (1993, pp. 34-35) argues that depression is common among bulimics because of their, feelings of demoralization about their behavior." Pike (1995) on the other hand, suggests that bulimics may have difficulties with both the identification and expression of negative emotional states. Moreover, Joiner, Schmidt, and Singh (1994, p. 200) argue that depression may affect body dissatisfaction through its effect on cognition and judgments about the physical self.

Depression is so common in bulimia nervosa that some researchers have suggested that depression is an "affective variant" and that the core underlying psychopathology of bulimia nervosa is major depression (Pope & Hudson, 1985; as cited in Williamson, 1990, p. 84). However, researchers generally agree that the evidence for depression as a cause of bulimia nervosa is not convincing and that the disorder is best regarded as being associated with secondary depression.

### **b: Eating Disorders and Personality Disorders**

In addition to the high rate of depression found in bulimics, a large body of evidence has been accumulating to support a high frequency of personality disorders among patients with eating disorders (Zerbe, 1993, pp. 36-37). Piran, Lerner, Garfinkel, Kennedy, and Brouillete (1988; as cited in Williamson, 1990, p. 94) reported that 39.5 percent of bulimics receive the diagnosis of borderline personality disorder, and that another 13.1 percent receive the diagnosis of histrionic personality disorder. They further report that anorectics are frequently diagnosed as either having avoidant (33%) or dependent (10%) personality disorders. According to Wonderlich, Fullerton, Swift, and Klein (1994), there appears to be a moderate comorbidity between eating disorders and personality disorders, with some specificity between dramatic-erratic personality features and bulimia and also between anxious-fearful personality traits and anorexia nervosa (Wonderlich & Mitchell, 1992; as cited in Wonderlich et al., 1994, p. 234).

### **c: Bulimia Nervosa and Substance Abuse**

Increasing evidence shows that a large number of bulimics also have problems with substance abuse. Most studies have found that up to 50 percent of patients with bulimia nervosa also have a current or past history of substance abuse. One explanation for the comorbidity of eating disorders and substance abuse is based on the theory of "an addictive personality" which predisposes an individual to become addicted to any one or more substances (or behaviors). The suggestion that drug and alcohol abuse occurs more often in bulimics is based on the hypothesis of impaired impulse control. Researchers and clinicians agree that impulsivity is a key feature in both bulimia and substance abuse (Holderness, Brooks-Gunn, & Warren, 1994, p.28). Bulimics and those who abuse chemical substances are alike in that they lose voluntary control over highly destructive behaviors despite adverse consequences (Zerbe, 1993, pp. 224-225).

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## **STUDY OF EATING ATTITUDES AMONG ASIAN AND HISPANIC WOMEN LIVING IN THE UNITED STATES**

Although much has been written about the behavior and psychology of white, upper and middle-class women with eating disorders little has been written about the rapid movement of eating disorders across cultural, racial, and social boundaries. According to the 1990 population census, there are 22.4 million Hispanic Americans in the United States, given their growth rate, (53% between 1980-1990), they will become the largest ethnic group in North America around the year 2020 (Lonner & Malpass, 1994, p., 23). Paralleling the growing number of Hispanics in the United States has been the rapid influx of people of Asian decent. Because of the multicultural nature of the United States, one would assume that attention would have been paid to the role of culture and acculturation in the development of eating disorders. However, to date this has not been the case.

The aim of the present study is to determine the influence of ethnicity and longevity in the United States on the eating attitudes of minority women as measured by the Eating Disorders Inventory-2. Specifically, comparisons will be made between women of Hispanic or Asian background who have lived either briefly or more extensively in the United States. Furthermore, the performance of each of these groups will be compared to normative responses of eating disorder patients on the EDI-2.

It was hypothesized that as Hispanic and Asian female immigrants acculturate they increasingly adopt the more stringent eating attitudes of white American females. In other words, the longer immigrant women are exposed to the values and lifestyles of the United States, the more likely they are to develop eating attitudes which put them at a greater risk for an eating disorder. It was further hypothesized that Asian women would have more unhealthy eating attitudes than their Hispanic peers.

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## **METHOD**

### ***Subjects***

The sample was composed of Hispanic ( $n=24$ ) and Asian ( $n=26$ ) female undergraduates drawn from the subject pool of an introductory psychology class at a large public urban institution. Subjects represented the following countries: the Dominican Republic, El Salvador, Japan, Taiwan, and Hong Kong. The Hispanic group consisted of women living in the United States for less than five years ( $n = 11$ ) and women living in the United States for more than five years, including native-born Americans of Hispanic decent ( $n = 13$ ). The Asian group consisted of women living in the United States for less than five years ( $n= 14$ ) and women living in the United States for more than five years, including native-born Americans of Asian decent ( $n= 12$ ). The Hispanic women ranged in age from 17 to 23 with a mean age 19.8. The Asian women ranged in age from 18 to 25 with a mean age of 20.5.

### ***Tasks and Procedures***

Testing was completed during one afternoon session. A maximum of ten subjects were tested at half hour intervals. Each subject was given the Eating Disorders Inventory-2 (EDI-2), which included the original 64 item inventory (consisting of eight subscales) introduced in 1983. The current version--EDI-2--includes 27 additional items which add three new constructs (i.e., the provisional subscales: *asceticism*, *impulse regulation*, and *social insecurity*) to the measure. Garner et al. (1983, pp. 17-19) describe the item content of each of the eight original subscales as follows:

*Drive for thinness*: indicates excessive concern with dieting, weight, and thinness.

*Bulimia*: indicates the tendency toward bingeing (uncontrollable overeating) and the impulse to engage in self-induced vomiting.

*Body Dissatisfaction*: reflects the belief certain parts of the body are too fat or large (i.e., hips, thighs, buttocks).

*Ineffectiveness*: assesses feelings of general inadequacy, worthlessness, and the feeling of not being in control of one's life.

*Perfectionism*: indicates excessive personal expectations for superior achievement.

*Interpersonal Distrust*: reflects a sense of alienation and an inability to form close attachments with others.

*Interoceptive Awareness*: reflects a lack in confidence in recognizing and identifying emotions and sensations of hunger and satiety.

*Maturity Fears*: measures the wish to retreat to the security of the preadolescent years because of the demands of adulthood.

Garner et al. in the EDI-2 Professional Manual (1991, p. 6) describe the provisional subscales as follows:

*Asceticism*: measures the tendency to seek virtue through spiritual ideals such as self-discipline and self-denial.

*Impulse Regulation*: assesses a tendency toward impulsivity, substance abuse, recklessness, hostility, and self-destructiveness.

*Social Insecurity*: assesses the belief that social relationships are disappointing, unrewarding, and generally of poor quality.

All items, including the 27 additional items in the provisional subscales, were presented in a six-point, forced choice format requiring respondents to rate whether each item applied "always," "usually," "often, sometimes," "rarely," or "never." The EDI had been demonstrated to be highly reliable and valid (Garner et al., 1983).

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## **RESULTS**

The percentage of respondents who scored within the eating disorder range on each of the subscales (including the provisional subscales) is presented in Table 1.

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**TABLE 1**  
**Percentage of respondents who scored within the clinical range on the EDI-2**

Percentages		
Subscale	Hispanic	Asian
Drive for Thinness	0	15%
Bulimia	0	4%
Body Dissatisfaction	13%	15%
Ineffectiveness	8%	8%
Perfectionism	67%	35%
Interpersonal Distrust	42%	38%
Interoceptive Awareness	21%	15%
Maturity Fears	58%	81%
Asceticism	29%	38%
Impulse Regulation	29%	50%
Social Insecurity	8%	38%

A test for significance of difference between two proportions was used to test the difference between the proportion of subjects in the two cultural groups who scored within the clinical range on the EDI. There were statistically significant differences between the scores of the Hispanic and Asian participants on both the *perfectionism* subscale and the *social insecurity* provisional subscale. The Hispanic subjects scored significantly higher on the *perfectionism* subscale  $z = 2.29$   $p < .05$  when compared to the scores of the Asian subjects. However, the Asian subjects scored significantly higher on the *social insecurity* subscale  $z = 2.14$   $p < .05$  when compared to the scores of the Hispanic subjects.

The relationship between longevity in the United States and eating attitudes was tested using Pearson product-moment correlations. The correlations between the scores on the EDI and longevity for both the Hispanic and Asian groups are presented in Table 2.

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**TABLE 2**  
**Correlations between longevity in the United States and EDI-2 scores**

	Hispanic		Asian	
	Correlation	Significance Level	Correlation	Significance Level
Drive for Thinness	.01	ns	.60	.001
Bulimia	-.08	ns	-.16	ns
Body Dissatisfaction	.02	ns	.42	.05
Ineffectiveness	.17	ns	.14	ns
Perfectionism	-.11	ns	.28	ns
Interpersonal Distrust	-.07	ns	.01	ns
Interoceptive Awareness	.08	ns	.23	ns
Maturity Fears	.17	ns	-.01	ns
Asceticism	.15	ns	-.21	ns
Impulse Regulation	.09	ns	.45	.02
Social Insecurity	.02	ns	.51	.01

A number of statistically significant correlations between longevity in the United States and EDI subscale scores were obtained. However, all statistically significant correlations occurred within the Asian group. Statistically significant correlations were found in the following four subscales: the *drive for thinness* subscale,  $r(60) = .60$   $p < .001$ , the *body dissatisfaction* subscale,  $r(42) = .38$   $p < .05$ , the *impulse regulation* provisional subscale  $r(45) = .45$   $p < .02$ , and the *social insecurity* provisional subscale,  $r(51) = .49$   $p < .01$ . The present results confirm the hypothesis, at least with respect to Asian women, that the longer immigrant women are exposed to the values and lifestyles of the United States, the more likely they are to develop eating attitudes which may put them at a greater risk for developing an eating disorder. In addition, the data confirms the hypothesis that Asian participants would have more unhealthy eating attitudes than their Hispanic peers.

## **DISCUSSION**

This study of Hispanic and Asian women in the United States has confirmed the hypothesis that there are differences between these ethnic groups. It can be concluded that Asian women living in the United States have more unhealthy eating attitudes than do Hispanic women living in the United States.

It is important to note that the construct of "drive for thinness" was introduced by Bruch (1973) as a principal feature of eating disorders. This construct is essential in the clinical diagnosis of both anorexia nervosa and bulimia nervosa. This study showed that four of

the Asian participants ( $n=26$ ) scored within the range for eating disorder patients on the *drive for thinness* subscale. These results indicate that these individuals may be at an especially high risk for an eating disorder.

Garner (1991) cautions that high scores "do not mean that [these individuals have] an eating disorder or 'anorexia-like' psychopathology" (1991, p. 8). He further states that these individuals are probably highly "weight-preoccupied" and should be further assessed to determine if they meet the criteria for an eating disorder or a subclinical variant (Garner, 1991, p. 8).

The data in this study did not find a statistically significant relationship between longevity in the United States and elevated scores on the EDI for Hispanic participants. One possible explanation for these results is that in Latin America, the ideal of beauty may be deeply rooted in a view of femininity that is not characteristic of "a drive for thinness". The emphasis on slenderness may not be a criterion for beauty in Latin American culture. Thus the Latino view of femininity may be highly resistant to the influence of the American standard for female beauty.

There were statistically significant differences between the scores of the Hispanic and Asian participants on both the *perfectionism* subscale and the social insecurity provisional subscale. On the *perfectionism* subscale the Hispanic participants scored higher and with more frequency than the Asian participants. In contrast, on the *social insecurity* provisional subscale the Asian participants scored higher and with more frequency than the Hispanic participants. The higher scores and increased frequency in both the *perfectionism* and the *social insecurity* scales may indicate concerns in these areas of functioning. The elevated scores on these two subscales may be reflective of general problems associated with acculturative stress and need not indicate the presence of an eating disorder.

Because of vast cultural and language differences within this population, Asians have been hampered in their ability establish a large cohesive subculture. Moreover, the culture gap they have to cross and physical distance they have to travel may be wider than is the case with immigrants from the Caribbean and Central America. This may explain their heightened scores on the *social insecurity* subscale.

Interestingly, elevated scores on the *perfectionism* subscale in the Hispanic group were not anticipated and the reason for this outcome is unknown. These results may have been influenced by the small size of the sample ( $N=50$ ) or simply by chance.

Future research on American ethnic groups and eating attitudes would be best undertaken with a high degree of sensitivity to the culture of origin of the participants and their families. In particular, researchers must recognize the potential effects of the acculturation process on the eating attitudes of immigrant women.

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## **APPENDIX A** **Eating Disorder Inventory-2**

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