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Weight, Body Dissatisfaction, and Disordered Eating: Asian American Women's Perspectives

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Asian American women experience disordered eating and body dissatisfaction, which puts them at risk for eating disorders and medical complications, as well as depression, anxiety, and related mental health issues. Help-seeking is low, and clinician bias hampers referral for adequate treatment, suggesting need for greater understanding of cultural context. Asian Americans experience many of the same risk factors as do other groups; however, research has not examined their phenomenological experiences of these issues in the cultural context, or their perceptions of what has helped them heal. To address this gap in the literature, modified consensual qualitative analysis (CQR-M) was used to analyze written narratives from 109 Asian American women who identified as having had concerns with weight, body, or eating, out of 354 Asian American women who responded to an online survey on eating behaviors and attitudes, and family relationships. They were asked to describe (a) any problems with weight, body, and eating; (b) their perceptions of the causes; and (c) their perceptions of what had helped them heal (if that was the case). Results indicated that weight gain, mild body dissatisfaction, and desire to be thinner were the most common experiences, and nearly one quarter had engaged in disordered eating. Participants' perceptions of the causes included Asian culture's emphasis on thinness, family criticism of weight, developmental events, and comparison to other Asian women. They reported that positive changes came primarily from social support, increased physical activity, and a shift toward internal validation. Implications for clinical practice are provided.

Keywords: Asian American, eating disorders, disordered eating, body dissatisfaction, weight

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The dramatic rise of anorexia (AN) and bulimia (BN) in Western women in recent decades (Striegel-Moore & Bulik, 2007), and the devastating emotional and physical costs that can accompany them (Kashubeck-West & Mintz, 2001), have sustained a strong interest in etiology and treatment of disordered eating. Until relatively recently, eating and body issues were thought to afflict primarily affluent White girls and women of European descent, but it is increasingly evident that they are occurring across cultures and around the world, and that Asian American (AA) women are at risk (Cummins, Simmons, & Zane, 2005; Wildes, Emery, & Simons, 2001). However, the research with AAs is fraught with methodological problems, providing a confusing picture of prevalence and etiology, little on culture-specific factors, and even less regarding AA women's phenomenological experiences. We begin with a review of pertinent research, including some from Asian countries, in order to provide a context for Asian women living in the U.S. and for first- and second-generation AAs.

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Body Dissatisfaction in Asian American Women

Body dissatisfaction can be defined as "the negative subjective evaluations of one's physical body, such as figure, weight, stomach, and hips" (Stice & Shaw, 2002, p. 985) and affects close to half of all U.S. women (Grabe & Hyde, 2006). It is a mental health issue in its own right, correlated with depression (Grabe & Hyde, 2006), low self-esteem, and social anxiety (Koff, Benavage, & Wong, 2001), and is one of the most significant risk factors for eating disorders (EDs; Stice & Shaw, 2002). Feminist theorists have asserted that body dissatisfaction results from gendered issues of objectification and power (Myers, Ridolfi, Crowther, & Ciesla, 2012), and control (Lee & Katzman, 2002). It was thought to primarily impact European American (EA) women, possibly due to research suggesting that African American women have a cultural protection from it (Grabe & Hyde, 2006); however, the research is far less thorough and more mixed with regard to AA women. Some studies have suggested that AA women have less dissatisfaction than do EA women (e.g., Nouri, Hill, & Orrell-Valente, 2011); others that they have more (e.g., Forbes & Frederick, 2008); and others that they have the same (e.g., Gluck & Geliebter, 2002; Shaw, Ramirez, Trost, Randall, & Stice, 2004).

Use of small samples and measurements that are not validated for AAs, as well as failure to consider potential cultural differences, may account for some of these discrepancies (Cummins et al., 2005). For example, although weight is the primary distress for EAs, body and facial features were distress factors in addition to, or instead of, weight in two studies of AA women (Koff et al., 2001; Mintz & Kashubeck, 1999). Additionally, AAs are a diverse

group, consisting of people from numerous countries with varying traditions, and exhibiting differences in economic status, immigration history, and acculturation levels. Grouping disparate groups may lead to mixed results. A study across 22 countries indicated that the Asian women (from Japan, Korea, and Thailand) valued thinness with even more exacting standards than other ethnicities (Wardle, Haase, & Steptoe, 2006), suggesting similarities among the Asian cultures. On the other hand, in comparing AA groups, Yates, Edman, and Aruguete (2004) found that even though women of Japanese and Chinese descent both had low weights, only the Japanese had high levels of body dissatisfaction and a desire to lose weight. The authors speculated that Japanese women experience more gender role constraints than do Chinese women. Kawamura (2002) pointed out that, differences notwithstanding, certain commonalities among Asian cultures may impact the experience of body image and eating, such as adherence to a rigid and more defined social hierarchy, emotional restraint, desire for social approval, and reluctance to reflect poorly on the family. Additionally, AA women may be affected by racist and sexist stereotypes (Kawamura, 2002), including those that emphasize smallness and femininity, or Western ideals of beauty that they cannot possible meet (Hall, 1995). A healthy body image in the context of multiple cultural pressures requires more research. That AA women experience body dissatisfaction, however, is clear (Cummins et al., 2005; Grabe & Hyde, 2006).

Disordered Eating in Asian American Women

Disordered eating includes a range of disturbed eating practices, from dieting, to occasional binging and purging, to subclinical and full-syndrome ED diagnoses (Slevec & Tiggemann, 2011). Lifetime prevalence among females is thought to be .5% to 1% for AN, and 1% to 3% for BN; with 2% to 5% classified as ED Not Otherwise Specified (NOS), and 19% to 32% as symptomatic (Kashubeck-West & Mintz, 2001). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM 5*; American Psychiatric Association, 2013) has moved binge eating disorder (BED) from "NOS" to full ED, which will increase the prevalence for EDs. Regardless, *DSM* diagnoses have had a Eurocentric bias; for example, Asian women may not always endorse the criterion *fear of fat,* because the cultural context is different, and yet still suffer from AN (Lee & Katzman, 2002). In a rare, nationally representative survey study of AAs using ED diagnoses, women's prevalence rates were 0.12% for AN; 1.42% for BN; 2.67% for BED; and 4.71% for "any binge eating" (Nicdao, Hong, & Takeuchi, 2007). The authors recommended more flexibility in ED classification, concerned that at-risk AAs would not be identified.

Prevalence data for AAs remain contradictory, the result of small convenience samples, measures not validated for AAs, and varying definitions of EDs (Cummins et al., 2005). Furthermore, because EDs are relatively rare, symptoms and risk factors are often studied in nonclinical samples; given that not all symptoms lead to EDs, and that less is understood about subclinical symptoms, this is an imperfect but necessary compromise (Striegel-Moore & Bulik, 2007). However, the seriousness of EDs remains indisputable, including as it does painful emotional states, high comorbidity, and risk of death (Kashubeck-West & Mintz, 2001); hence, there is good reason to study symptoms and risk factors. A growing body of literature convincingly suggests that AA women are engaging in levels of disordered eating similar to those of EA's (e.g., Franko, Becker, Thomas, & Herzog, 2007; Shaw et al., 2004), and that AA women are indeed at risk (Cummins et al., 2005; Nicdao et al., 2007; Wildes et al., 2001).

Etiology of EDs is thought to include bio-genetic, psychosocial, and sociocultural factors, but is still not well understood (Striegel-Moore & Bulik, 2007). General psychiatric factors likely contribute to both AN and BN; risks for AN include genetic predispositions to thinness, obsessiveness, and perfectionism; and risks for BN include dieting, childhood weight problems, and criticism from others regarding eating and weight (Schmidt, 2002). The most consistently reported sociocultural risk factors for EDs are body dissatisfaction, dieting, thin-ideal internalization (the personal adoption of society's value of thinness), and having a high weight (Striegel-Moore & Bulik, 2007). In the U.S., etiology research has been conducted overwhelmingly with EA women; this imbalance needs to be addressed for women of color (Striegel-Moore & Bulik, 2007). Pike and Borovoy (2004) explored EDs in Japan and asserted that ". . . certain risk factors and social tensions appear to be shared across cultures" (p. 524), but that "an analysis of culture is essential to truly understanding the way in which such risk factors are experienced, understood, and managed" (p. 524). As an example, understanding how perfectionism and response to criticism are experienced culturally may be crucial.

ED rates are lower in Asian countries, with the exception of Japan, but may be on the rise with the spread of Western influence (Yates et al., 2004), particularly in higher income countries like Japan, South Korea, Taiwan, and Singapore, as well as in large cities in China and Indonesia (Lee & Katzman, 2002). However, Jung and Forbes (2006) asserted that EDs are not due to Western influence alone, but may be coping strategies used in the face of rapid social change, in which new economic opportunities and increasing freedoms are in conflict with traditional values. It has been hypothesized, for example, that EDs provide Asian and AA women a way of managing family and gender role distress without violating traditional gender norms (Pike & Borovoy, 2004; Yokoyama, 2007). The issues are complex, both in Asian countries and for Asian women in the U.S., and this may also be why no clear picture has emerged with regard to acculturation and disordered eating (Cummins et al., 2005; Wonderlich, Joiner, Williamson, & Crosby, 2007).

In summary, not only do AA women *not* benefit from cultural buffers with regard to body dissatisfaction and disordered eating (as was previously thought), but they may in fact be subject to additional, native cultural factors that further predispose them (Wonderlich et al., 2007). Moreover, help-seeking is low (Nicdao et al., 2007), appropriate referral by health practitioners is lacking (Franko et al., 2007), and AAs are virtually absent from the treatment literature (Stein et al., 2001). Understanding cultural context is critical to all the issues discussed thus far, and methodology beyond survey data is needed to clarify it. Qualitative research has unique potential for describing seldom-studied phenomena (Spangler, Liu, & Hill, 2012). The purpose of the present study is to describe some of the experiences of AA women with eating and body issues. Our objective was to hear, from AA women themselves, how they characterize symptoms, causes, and approach toward wellness.

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Method

Participants

A total of 354 Asian American women responded to the online survey, and of those, 109 women (one transgendered) responded to the open-ended questions. Ninety-seven (89%) were AA of the following descents: Chinese ($n = 25$); Thai ($n = 23$); Korean, Srilankan, and multiethnic ($n = 12$ for each); Filipina and Vietnamese ($n = 6$ for each); Japanese ($n = 5$); Indian ($n = 3$); Cambodian ($n = 2$); and Malaysian, Pacific Islander, and Taiwanese ($n = 1$ for each). Twelve (11%) were Asian nationals who currently reside in the United States. Thirty-seven (33.6%) identified as first-generation AA; 55 (50.5%) as second-generation; 8 (7.3%) as third-generation; and 4 (3.7%) as fourth-generation and beyond. The average age was 29.31 years ($SD = 8.26$). Nearly half (45.9%) identified as middle-class; 33% identified as upper-middle or upper-class; and 21.1% identified as lower-middle or lower-class. Eighteen indicated that they had had an ED at some time, and five indicated they had received treatment.

Procedure

Following IRB approval, participants were recruited through electronic mailing lists of professional psychology organizations, university student groups, Facebook invitations, and researchers' personal and community contacts. Data from this study represent the narrative responses to three open-ended questions included in a larger-scale data collection of survey questions regarding family relationships and eating behaviors. Participants were invited to answer the three open-ended questions to whatever degree and at whatever length they chose if they had experience, in some capacity, with weight issues, body dissatisfaction, or disordered eating.

Data Analysis

We used a modified version of Consensual Qualitative Research (CQR; Hill et al., 2005). The original CQR is typically used to code data from in-depth interviews with eight to 15 participants, and formal recommendations for a modified version were recently provided (CQR-M; Spangler et al., 2012). This process is specifically for use with brief written narratives (which by nature have limited context) from larger samples; and it draws on CQR and discovery-oriented and exploratory research. The primary difference from the original CQR is that data are placed directly into categories without constructing *core ideas* (a process to make sure that data have been interpreted within the context). What is retained from the original, and is especially important in terms of establishing the trustworthiness of the analysis, is the use of extensive team consensus in coding.

The questions. Consistent with Spangler, Liu, and Hill's (2012) recommendations, questions were derived from both our understanding of gaps in the literature and from our previous research. We also sought to provide participants with an avenue that was feasible (i.e., brief), respectful of their experience (e.g., open-ended questions to be answered at any length), and culturally accessible (i.e., providing an anonymous and written avenue for describing personal experiences that otherwise might be difficult to reveal; see Kim, Brenner, Liang, & Asay, 2003). Participants were invited to respond to the following questions: (a) If you have struggled with weight, eating, or body image, please describe the problem; (b) What is your understanding about how you developed these behaviors and attitudes?; and (c) If you have gotten better and/or have improved, what is your understanding of what helped you get better?

The researchers. Both authors are women psychologists (European American and Taiwanese American) with degrees in counseling psychology, experience in the treatment of disordered eating, and experience conducting qualitative research. The data analysis team consisted of three Masters-level counseling students familiar with the disordered eating literature and/or Asian American culture (all women; two European American and one Vietnamese American). CQR-M emphasizes that teams discuss their biases and approach to the data. The authors had stronger preconceptions based on experience and expectations (e.g., that participants would cite family pressure to achieve socially and professionally). The students processed their ideas of cultural "blind spots," conceptions of "healthy" versus disordered eating, perceptions regarding body image, and the potential to defer to their professors.

CQR-M process. Our process was consistent with recommendations from Spangler et al. (2012). The first author read through all the data and developed a starting list of *categories* within the responses to the three questions, which were treated as preliminary *domains.* Although the domains conformed to the three questions as a starting point, we added a fourth for a time but concluded later that the data fit better into the original three. Responses to the questions were not coded exclusively within their domains, as often they belonged better to a different domain or to more than one. Categories changed a great deal during the process of consensus.

Next, both authors trained the "judges" (graduate students) in coding. CQR-M does not seek interrater reliability; rather, discussion and eventual consensus are considered a better process for countering bias and coming to thoughtful interpretations of data. The entire group worked through a sample of the data together, questioning each other's perceptions, and using a "bottom up" approach to make sure that coding reflected the participants' words rather than our own notions or overinterpretations. Responses, which ranged from single sentences to lengthy paragraphs, were coded in their entirety into one or more categories. As it became clear that certain categories were too small, they were incorporated into larger, more abstract categories.

Over the following weeks, the judges independently coded the remaining data and met with each other multiple times to achieve consensus. The first author then reviewed the judges' coding and category changes and negotiated with them until consensus was reached. The second author functioned as an auditor, reviewing all coding again and negotiating proposed changes with the first author. Then the first author assessed the data one last time to make sure all coding agreed with the final consensus. Finally, response frequency was calculated using proportions (see Table 1). Throughout the process, the authors used the NVivo software program to track and sort the data, allowing us to modify categories and coding as the process developed, and to review each category for consistency and frequency.

Table 1
Categories and Frequencies of Responses

Category	*n*	%
Q1: If you have struggled with weight, eating, or body image, please describe the problem:		
Changes in weight		
Weight gain	29	27
Weight loss	11	10
Body dissatisfaction		
Desire to lose weight	35	32
Body dissatisfaction, mild	23	21
Dislike of specific body part or feature	16	15
Feel different due to body part or feature	10	9
Body dissatisfaction, severe	9	8
Feel unattractive	4	4
Desire to gain weight	3	3
Disordered behaviors		
Restrictive eating	19	17
Overeating	14	13
Compensatory behaviors	8	7
Other		
Emotional distress	13	12
Comorbidity	6	6
Miscellaneous	1	1
Not applicable/No response	1	1
Q2: What is your understanding about how you developed these behaviors and attitudes?		
Culturally defined media and beauty norms		
Specifically Asian norms	25	23
Unspecified norms	19	17
Specifically western mainstream norms	4	4
Mixed Asian and western norms	4	4
Family		
Family criticism of weight	32	29
Family eating norms	9	8
Mixed messages about weight and eating	8	7
Family messages about appearance	5	5
Family focus on accomplishments	5	5
Individual		
Developmental changes	20	18
Strategies to manage distress	15	14
History of overweight	11	10
Internalization of E\external standards	10	9
High expectations of self	6	6
Interpersonal		
Making social comparisons	19	17
Experiencing teasing and insults	12	11
Conforming to peer norms	4	4
Other		
Protective factors	6	6
Miscellaneous	5	5
Not applicable/No response	17	16
Q3: What is your understanding of what helped you get better?		
Internal strategies		
Shift to internal validation	26	24
Shift to valuing physical health	17	16
Critical awareness of sociocultural influences	5	5
External strategies		
Increasing activity level	21	19
Valuing social support	19	17
Setting boundaries with family	6	6
Having parental support	6	6
Seeking therapeutic intervention	6	6
Other		
Still struggling	22	20
Miscellaneous	8	7
Not applicable/No response	21	19

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Results

The complete list of categories and frequencies is provided in Table 1. We discuss only the most common categories. We do not correct participants' grammar or spelling.

The Struggle With Weight, Body Image, and Eating

Experience of weight gain, desire to lose weight, and mild body dissatisfaction were the most common issues reported (occasionally due to developmental issues like pregnancy or aging). Most comments, however, reflected conflicting emotions even when dissatisfaction was not extreme. A typical response was: "haven't really struggled seriously but many times I [*sic*] am overly concerned with how I look and how much I weight [*sic*], and often it makes me feel sadder than I normally would." The following comment was typical of mild dissatisfaction in the context of family influence:

> I have always been the fattest in my family which my family members are quick to point out. However, when I recently lost a significant amount of weight, my family members are the first to point out that I'm too skinny. This has me to have [*sic*] a slightly (but not clinical-level) distorted level of my body image.

More distress—notably guilt, sadness, and shame—were evidenced in comments by participants who identified as having had more serious body dissatisfaction or disordered eating. One woman explained the pervasive and complex quality of her experience with body dissatisfaction:

> . . . I find it difficult to be satisfied with my body because part of me believes that my value as a person is related to how I look while the academic and socially conscious part of me wants to reject these socialized norms of beauty. I often feel a mixture of sadness and anger when thinking about my weight. I feel sadness because I am dissatisfied with my body and wish I could feel beautiful and I feel anger at myself for buying into the societal beliefs of beauty and for letting others make me feel bad.

A total of 27 (24.8%) of the participants reported one or more disordered eating behaviors, primarily restricting and overeating (half of which identified as binging); and, to a lesser extent, compensatory behaviors of vomiting and overexercising. The following comment was typical, in that the participant reported a number of disordered eating behaviors but fell short of stating she had a full-syndrome ED:

> I've heard that I was fat since I was in kindergarten. Struggled with a lifetime of shame (truth be told, I was never obese, just a little chubby at certain points in my life), starving, bingeing, wishing I had the willpower to be full-on anorexic or wishing I contracted a terrible disease that would cause me to waste away. My dad would always compare me to my thin friends. I was very unhappy with my weight.

The Development of Attitudes and Behaviors Related to Body, Weight, and Eating

Participants attributed their struggles to a variety of factors, which we categorized as *familial*, *cultural, individual*, and *interpersonal*.

Familial. After individual desire to lose weight, the role of parents and extended family in weight criticism (all but one for being

"overweight") was the most dominant category (29%), and permeated across many of the descriptions of body dissatisfaction and disordered eating. Participants often cited the bluntness of family communication. A typical comment was, "When I'm heavier 58 kg and above, the elders in my family will say that I'm fat constantly to my face. My dad used to say things like 'your arms are as thick as my thighs.'" Another wrote, "My family has always been very frank with one another about weight (e.g., 'You're to [*sic*] skinny, eat more!' 'Wow, you got fat!')." Another woman put the appearance issue explicitly in terms of Asian cultural norms: "How I look also reflects on my family, by the way. If I'm an ugly girl, my family would lose face!!"

Cultural. Nearly half of the participants cited media and societal norms regarding beauty as a major influence. One woman captured the combined influence of EA and Asian norms, but also emphasized another common element, that of feeling less body distress around non-Asians:

> Even my [sic] impossibly high mainstream American norms, I do not feel thin, so the images of "ideal" White women have influenced me. But I am additionally influenced by images I see in the Chinese, Korean, and Japanese media that I see. My non-Asian friends and colleagues might think I am small (mostly because I am shorter than they are) and not fat, and I might feel "ok" around them, but around my Asian friends, I feel overweight.

Many participants (25) expressed distress exclusively with Asian culture's emphasis on thinness. Although some of these comments were relatively brief, they were strikingly similar in tone, often referencing the family's role and the country of origin. One woman wrote: "Mother, older female family members, Korean culture and media—they are preoccupied with being slim, being fat is one of the worst things for a woman. My mother used to talk about how overweight individuals would get severely teased." A few referenced the stress of going to Asia (e.g., "It's hard because AA women are so skinny, especially when you go to Asia, you feel super fat").

Individual. This theme refers to developmental experiences and reflections of a more internal nature. The dominant category, *developmental changes*, includes struggles related to puberty, beginning college, having a baby, aging, ceasing participation in a sport, or suffering a loss. These were often stress-related transitions, and some women explicitly noted that their eating behavior served the function of helping manage stress or difficult emotions.

Interpersonal. Most of the 19 women who cited *social comparisons* reported comparing themselves with other Asian girls when growing up. The following comment is typical and incorporates notions about not having a stereotypical Asian body, not fitting in, and the power of comparison:

> As an Asian female, I feel as if I need to be thin and petite, but I have a bigger mass than most Asian women. I tried to lose weight and have lost a lot of weight, but I still don't feel like I fit in with Asian women because I have big bones. I feel weird when I'm with many other Asian women and everyone's more petite and feminine than me. I also feel very conscious about myself when eating with others because I don't want them to think I eat a lot and that I am big.

Getting Better: Participants Identify Sources of Strength

A majority of participants indicated that they had experienced improvement in their symptoms or body image. However, 21 (19%) did not answer the question and 22 (20%) indicated that they were still struggling. Some in the latter group stated that they had not gotten better at all; others presented a more mixed picture, such as the woman who said she had lost weight and was happy with how she looked now, but ". . . I still have problems with binge eating, and I still have nightmares of gaining weight." We divided participants' paths to greater wellness into *internal* and *external* strategies.

Internal strategies. This category reflects change attributed to something self-instigated. Many described changes that indicated a *shift toward internal validation,* such as increased self-acceptance and self-confidence, decreased sensitivity to others' comments, creating their own standards, and appreciating themselves for attributes other than appearance. A typical comment came from a woman who reported increased ". . . appreciation for myself and other accomplishments besides my looks—education, job, performance in various areas such as public speaking, and so forth. Also stronger and healthier relationships with family, friends, coworkers, and feeling a sense of meaning and purpose in my life." A number of women indicated a *shift toward valuing physical health,* and in many cases an appreciation of their bodies' abilities.

External strategies. This category reflects change attributed to activities of an outward or societal nature. Numerous women reported becoming physically active. *Social support* was also important, and many women cited loving friends, partners, and parents, as well as learning to set boundaries with family.

Summary of Results

Although nearly a quarter of participants had engaged in disordered eating, and a few had suffered serious EDs and serious body dissatisfaction, the more common issues were weight gain, mild body dissatisfaction, and the desire to be thinner. Participants cited family use of criticism, Asian culture's emphasis on thinness, specific life events, and social comparison as influential in developing eating and body issues. They reported that positive changes came primarily from social support, increased physical activity, and an internal sense of validation.

Discussion

This exploratory and descriptive study provides insight into the subjective experiences of mostly first- and second-generation AA women who identified as having struggled with eating or body issues. The issues included a range of body dissatisfaction from mild to severe, disordered eating behaviors of binging, restricting, and purging, and full-syndrome anorexia and bulimia.

The strongest themes involved the participants' explanations of sociocultural influences, particularly around the pressure to be thin. Although the results are consistent with well-documented pressures by family, media, and peers (Stice & Shaw, 2002), the present research adds to the extant literature by revealing ways in which AA culture shapes that experience.

It is widely speculated that a risk for body and eating disturbance in AA women is the impossibility of meeting Western ideals of beauty (Hall, 1995; Yokoyama, 2007), and a recent study found that AA women were impacted by internalization of Western thinness ideals in ways similar to those of the European American

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sample (Nouri et al., 2011). Although previous research (Koff et al., 2001; Mintz & Kashubeck, 1999) suggested that body dissatisfaction in AA women includes distress with non-Western features, this was in fact rare in our sample. It is possible that older participants had moved beyond an earlier stage of wanting Western features, or that participants were less likely to volunteer this information (as opposed to endorsing survey items). Participants were more likely to comment on stomach fat, which could be interpreted as not having a Western "hourglass" figure (e.g., one participant wrote that she wished she would gain weight in her breasts and butt instead), but could also be the result of the age of the sample (approximately 30) and the fact that many had borne children.

There was little ambivalence in our sample concerning the desire to be thin, however. Body dissatisfaction was overwhelmingly described by participants in terms of weight gain and "feeling fat," and although this was not a comparison study, it would seem to contradict research that suggests AAs have less body dissatisfaction than do European Americans (e.g., Nouri et al., 2011). Body dissatisfaction in women tends to increase as weight increases (Yates et al., 2004), but historically (and perhaps still in more rural areas of Asia), a plumper female figure was valued; however, this is not the case in modern Asian societies (Kawamura, 2002) or among AAs (Grabe & Hyde, 2006). In fact, consistent with a number of studies (Barnett, Keel, & Conoscenti, 2001; Wardle et al., 2006), many participants indicated that an even stricter standard of thinness applied to them as AA women.

The reasons given for this stricter standard focused on Asian culture and familial enforcing of the thinness ethic. A few participants stated that they had indeed been overweight, and endured hurtful criticism from family; others indicated that they had not been overweight, but that they had been criticized or teased because they were not as slim as other Asian girls. Although the norm of guiding children through comparison and shaming, when applied to eating and weight, has been hypothesized to impact AA girls (e.g., Ting & Hwang, 2007), there are few empirical studies that examine this phenomenon. Isono, Watkins, and Lian's (2009) qualitative study of young women with EDs in Singapore revealed painful recollections of weight bias from family and community, and this perhaps comes closest to our findings.

Weight-related teasing has been linked to increased risk for EDs (Slevec & Tiggemann, 2011), and one study, examining the teasing of South AA girls specifically, resulted in similar findings (Reddy & Crowther, 2007). Further, although they could find no information on AAs, Slevec and Tiggemann (2011) concluded that early teasing "may have an enduring adverse impact on midlife body image and eating practices" (p. 521), which may help explain our sample's focus on criticism. The research in this area relies primarily on participants' memories, and some evidence (primarily with European Americans) suggests that people with EDs perceive parents as more focused on appearance than they actually are (Vandereycken, 2002). Nevertheless, the subjective experience of nearly a third of our participants was that teasing, and particularly family criticism, were harmful and impactful. More research is required, but it is possible that weight-related criticism may be more common among AAs than among European Americans due to (a) cultural styles of communication, and (b) the desire for children to present well. It is also possible that AAs feel more distress when they observe contrasts between their own families' communication styles and those of their European American peers' families (Smart, Tsong, Mejía, Hayashino, & Braaten, 2011).

That AA women are presumed to be thin was also evident through the means of comparison with others, primarily to other AA girls and women (comparison to European Americans generally made participants feel better about their weight). We are not aware of any studies that explore AA girls' or women's comparisons to their own cultural peer groups, but research on appearance-based social comparison theory (adapted from Festinger, as cited in Myers et al., 2012), which explores comparison to peers and people considered "superior," and its impact on body dissatisfaction, is growing and warrants further exploration.

Participants also cited developmental events (including transition states, as well as life events occurring as part of the developmental process) as triggers for eating and body issues, although they provided less detail in this area. The existing research rarely includes AAs, but perceived stress and stressful life events likely play a role in disordered eating (see Ball & Lee, 2000), and the present study's data are partially consistent with a diverse sample study showing that credit card debt, partner break-up, and death of a loved one were the highest stressors associated with disordered eating (Loth, van den Berg, Eisenberg, & Neumark-Sztainer, 2008). Many comments were consistent with research related to adolescence, in which weight gain at puberty, relationship changes, and starting college are among transitions that, under a combination of circumstances, can trigger eating problems (Smolak & Levine, 1996). A number of comments related to weight gain after giving birth and weight gain associated with aging; some of these appeared to reflect self-criticism, but some reflected parental criticism. Although very little has been done with AAs in this age range, Slevec and Tiggemann (2011) maintain that body dissatisfaction and disordered eating among middle-aged women is common. Weight-related teasing and criticism of middle-aged women were also noted in their review; it was, however, in connection to partners rather than parents. It is possible that parental criticism of adult daughters is more common among AAs than among European Americans.

Our data primarily reflect the sociocultural context leading to body dissatisfaction and disordered eating, and this is likely due to the nonclinical sample and the fact that sociocultural factors may be more relevant to subclinical behaviors and body dissatisfaction than to full-syndrome EDs (Wildes et al., 2001). As was stated earlier, in order to experience more serious problems, a combination of bio-genetic and psychological–sociocultural factors would likely be occurring (Schmidt, 2002); and indeed, the five women with full-syndrome EDs provided explanations that were multifaceted, citing perfectionism, obsessive traits, and relationship and mood problems—and in one case, gender identity issues—in addition to culture and family.

Only four women (one with BN, one with AN, one who binged and purged occasionally, and one who overate) reported benefitting from therapy or a combination of therapy and antidepressants. Two others reported benefitting from yoga and mindfulness. Very little research has examined recovery from EDs in AA women, or positive changes in AA women with body dissatisfaction and subclinical eating issues. The majority of participants who reported improvement cited nontherapy related changes. The most common element involved shifting to more internal forms of validation:

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learning to focus on attributes other than appearance, putting weight into perspective, and gaining self-acceptance. For many participants, this involved a focus on physical health over appearance and education re healthy behaviors. Many also reported a kind of empowerment when they began to appreciate their bodies' functionality.

Research on the phenomenology of recovery typically involves qualitative research with European American women who experienced full-syndrome EDs, but some similarities do exist with the present study. For example, Krentz, Chew, and Arthur (2005) found that recovery from binge eating disorder included a shift toward self-acceptance, a modified relationship to the body, changes in relationships, and better connection with others. Social support has also been documented in the recovery from EDs (e.g., Linville, Brown, Sturm, & McDougal, 2012). Although a small percentage of participants felt that parental support was valuable, an equal number felt that distance and boundary-setting with parents were needed.

Clinical Implications

Despite the struggles that participants identified, a good deal of resilience emerged from the comments as a whole, and the qualitative nature of the data showed how the participants could experience contradictory thoughts and emotions at the same time (e.g., being affected by media and family, but resisting too). Small groups reported having resisted cultural and family pressures all along, engaging in critical analysis of media culture and cultivating awareness of a tendency to internalize outside messages. Many appeared resourceful in finding personal paths toward healing and support. These are strengths that can be utilized in prevention and treatment.

At the same time, it was clear that as many as 20%—and possibly up to 39%, if those indicating "no response" are included—were still struggling, and that very few had sought help. A small group reported continuing to struggle with more serious issues. This is of great concern, given the barriers to receiving help (Franko et al., 2007). Additionally, this study suggests that even among AA women without serious EDs, there are stresses regarding weight gain and pressure to be thin, even for post-partum and middle-aged AA women. Indeed, the strong identification of family criticism, teasing, and shaming suggests that they may pose a particular risk for first- and second-generation AA women, and that culturally relevant education, prevention, and therapy efforts could be focused in this area.

Ting and Hwang (2007) suggested that culturally sensitive family therapy address parental use of shame and criticism. Therapists can help parents understand that their daughters may interpret their attempts to help through criticism as particularly painful, framing this for both parties as an acculturative difference rather than a hostile or uncaring one. Of course, therapists must be alert to acts of abusive behavior as well. Significant for many women in this study was the development of close relationships and intimacy outside the family, and therapists should not underestimate the power of helping to strengthen interpersonal skills. Finally, encouraging clients to be aware of and analyze both mainstream and Asian media and the potentially negative effects of social comparison can be helpful.

Limitations and Directions for Future Research

Results of this study must be considered in light of a number of limitations. Although qualitative data from slightly more than 100 participants is appropriate for exploratory research of a little-studied topic, and indeed yielded important insights, the nature of the data does not provide the more in-depth analysis that comes from smaller, interview-based qualitative studies. The online, anonymous format may have encouraged candor in an AA sample, and the open-ended, unrestrained format allowed participants to write freely of their own experiences. On the other hand, participation was limited to those with access to the Internet, and without facilitator prompting some participants may have forgotten important material or chosen not to reveal it. Additionally, because of the brief, noncontextual data, it was not always clear what participants meant by certain terms (e.g., "healthy"). Although the online format had the advantage of accessing people from across the U.S., and multiple Asian groups were represented, there are inherent problems with grouping all Asians together. Finally, participants were largely middle- and upper-middle class, which may have skewed results regarding access to resources for self-care. The fact that the average age was 29.31 likely accounts for body image concerns following pregnancy and middle age. Nevertheless, we believe that the methodology used allowed for a greater response and openness from AA women regarding weight, body image, and eating than has yet been done, and that several themes were so consistent that they warrant future study.

It seems likely, as others have pointed out, that many risk factors discussed here are similar across cultures, but that the varieties of experience within cultural contexts are important to understand (Pike & Borovoy, 2004). Our study suggests that weight-related family criticism (from childhood and into adult life) and social comparison to Asian peers require further investigation. In addition, thin-ideal internalization has been defined in the U.S. literature primarily as an adoption of mainstream culture's standards (Nouri et al., 2011). However, first- and second-generation AAs may aspire to a slightly different thin ideal, one that is even slimmer and incorporates messages from both mainstream and Asian culture. Beyond the obvious need for more work in prevalence, symptom presentation, and treatment, future research should focus on first- and second-generation AAs, who may in fact be more at risk than other generations, not because of acculturation issues directly, but because they are affected by a double set of beauty norms, and feel intense pressure to succeed both socially and professionally, in two cultures.

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