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The Role of Cultural Beliefs in Disordered Eating Among Asian-American Women

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Recent research confirms that Asian Americans (AAs) experience disordered eating (including full-syndrome and subclinical symptoms of eating disorders). However, the role of culture in disordered eating has largely focused on acculturation, with inconclusive results, and although some traditional cultural values have been hypothesized to contribute to risk for eating disorders, there has been little empirical research to support these claims. This exploratory study examines the role of culture in AA women's disordered eating from 2 perspectives: adherence to 5 dominant traditional cultural values using the Asian American Value Scale–Multidimensional (Kim, Li, & Ng, 2005) and generational status. A diverse community sample of 241 AA women participated in an online survey. Although there were no generational differences in cultural beliefs, second-generation women reported significantly more disordered eating than did their first- and third-generation (and above) counterparts, suggesting a potentially significant role of cultural conflict, or biculturative stress, in disordered eating. Among the cultural beliefs, endorsement of Family Recognition Through Achievement and Emotional Self-Control were the 2 significant risk factors for overall disordered eating assessed by the SCOFF (Morgan, Reid, & Lacey, 1999). Results of this study offer support for more exploration of cultural context in the risk for disordered eating in AA women in several ways, including the role of biculturative stress, the perils of the perceived pressure to achieve, and the possible use of disordered eating as a method of expressing distress in a covert manner. Implications for clinical interventions are discussed.

Keywords: Asian-American women, eating disorders, cultural beliefs, disordered eating, traditional cultural values

Because of the potentially devastating medical (e.g., heart attack, bone density loss, death) and psychological effects (e.g., depression, suicide, anxiety) of eating disorders (EDs) on individuals and their families, the National Institute for Mental Health (NIMH) has identified advancing the understanding and treatment of EDs as an issue of immense public health importance (Chavez & Insel, 2007). Women also are significantly more affected by EDs than are men (Fairburn & Harrison, 2003). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition; *DSM–5*; American Psychiatric Association, 2013), the 12-month prevalence in females is approximately 0.4% for anorexia, 1–1.5% for bulimia, and 1.6% for binge eating disorder. Although strong prevalence data on EDs in Asian Americans (AAs) are scant, and much of the research over the last 2 decades has produced conflicting reports on whether they have less, more, or equal symptomatology as do White European Americans (see Cummins, Simmons, & Zane, 2005, for a review), it is now evident that disordered eating (i.e., full-syndrome EDs as well as subclinical symptoms) is experienced by Asians and AAs in the United States (Franko, Becker, Thomas, & Herzog, 2007; Nicdao, Hong, & Takeuchi, 2007) and in industrialized cultures around the world (Cummins et al., 2005; Wildes, Emery, & Simons, 2001). One study with a nationally representative sample found AA women's prevalence rates were 0.12% for anorexia, 1.42% for bulimia, 2.67% for binge eating disorder, and 4.71% for "any binge eating" (Nicdao et al., 2007). However, the actual disturbed eating prevalence may be even higher for AAs than currently estimated because AAs tend not to utilize mental health services in general (e.g., Chu, Hsieh, & Tokars, 2011; Gupta, Szymanski, & Leong, 2011), leaving them out of clinical prevalence data.

Cultural Context of Risk Factors

Pathways to disordered eating are multiple, exceedingly complex, and still not well understood (Striegel-Moore & Bulik, 2007). Etiology is thought to include a range of genetic, psychological, and sociocultural factors, which include perfectionism and obsessiveness for anorexia (Wonderlich, 2002) and childhood weight problems, teasing, criticism, and dieting for bulimia (Schmidt, 2002). AAs are rarely included (or identified) in large-scale genetic or family studies (see Cummins, Lehman, & Liu, 2012, for a review), and much of the research on AAs has focused on the influences of Westernization or industrialization, which is often referred to as "acculturation." However, the relationship between acculturation and disordered eating has been inconclusive (Cummins et al., 2005). Although many studies did not find any association (e.g., Haudek, Rorty, & Henker, 1999; Yoshimura, 1995),

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some found immigrant women with more traditional cultural orientation reporting a greater risk of disordered eating behaviors (e.g., Mumford, Whitehouse, & Platts, 1991), and yet others found higher levels of acculturation/Westernization to be a risk factor in AA women (e.g., Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000) and in Asian college female students studying in the United States (Davis & Katzman, 1999). Results from studies comparing AA immigrant women and their counterparts in Asian countries of origin have also been inconclusive. For example, second-generation Korean-American women were found to have less disordered eating behaviors than first-generation women (immigrated after age 7 years) and Korean nationals (in Korea; Jackson, Keel, & Ho Lee, 2006), but South Asian immigrants in the United Kingdom had more disordered eating attitudes than their counterparts in their country of origin (Mumford, Whitehouse, & Choudry, 1992). These inconsistencies are likely due to numerous methodological issues of measurement and sampling (Cummins et al., 2005) and the differing operationalization of the role of "culture," ranging from behavioral adaptation of the mainstream culture (e.g., language, food and music preferences) to cultural values (e.g., culturally based religious beliefs and tradition; Ahmad, Waller, & Verduyn, 1994). Some have also suggested that indigenous cultural emphases (e.g., Asian beauty ideals, self-restrictive behaviors as a valued personality trait) might also contribute to the disordered behaviors and attitudes for AA women (Jackson, Keel, & Ho Lee, 2006).

To better understand the cultural beliefs of a wide range of AA women, from first-generation adult immigrants to those whose families have been in the United States for multiple generations, this study examines the roles of cultural socialization from two perspectives: (a) traditional cultural values, which focus on the integration of traditional cultural values into identity, with implications for how these influence the ways in which psychological problems are manifested, as well as individuals' beliefs about problem etiology and emotion expression (Atkinson, Morten, & Sue, 1998); and (b) immigration generational status, a simple method of assessing the proximity of people to their culture of origin, with implications regarding to what degree people are needing to negotiate the values of culture of origin and mainstream U.S. culture, expecting that first-generation adult immigrants would have closer proximity to their cultural of origin and more distant proximity to the U.S. mainstream culture, and fifth-generation AAs would have more distant proximity to their culture of origin and closer proximity to the U.S. mainstream culture (Kim, 2009; Kim, Atkinson, & Yang, 1999).

Cultural Values and Beliefs

Because findings of the role of acculturation in the development of EDs have been inconsistent, Cummins et al. (2012) advocated for exploring culturally influenced factors such as beliefs about self-control and individuation, emotional expression and regulation, and individualism and collectivism. Kim and his colleagues (Kim, Li, & Ng, 2005) developed the Asian American Value Scale–Multidimensional (AAVSM) and assert that the five dimensions of *Collectivism, Conformity to Norms, Emotional Self-Control, Family Recognition Through Achievement*, and *Humility* represent traditional Asian values that cut across various Asian cultures and may have important implications for mental health. To our knowledge, few researchers have directly assessed the potential contributions of these specific dimensions of cultural values to the development of EDs. Kawamura (2011) hypothesized that aspects of collectivism, conformity, emotional restraint, and humility may contribute to AA women's body dissatisfaction, which is a risk factor for EDs and disordered eating. For example, although collectivistic cultural values may provide benefits of interdependence, harmony, and a sense of community, some AA women may feel increased pressure to suppress their emotional expression, to act in a manner that does not reflect poorly on the group, or to meet family's high standards out of duty and honor. Furthermore, AA women who deviate too far from the cultural norms of beauty may experience criticism, and they may seek to maintain a "perfect" physical appearance to avoid embarrassing the family.

There is some initial evidence connecting achievement and its importance to the family in AA women's disordered eating. In one qualitative study (Smart, Tsong, Mejía, Hayashino, & Braaten, 2011), therapists reported that many of their AA clients with disordered eating believed that being very slim (slimmer than the mainstream U.S. ideal) was a necessary aspect of pleasing parents and conforming to expectations of the AA community and it was an important aspect of overall achievement. Indeed, compared with other ethnic groups, AAs have reported extreme concerns about meeting high parental expectations in academics, career, and appearance (Peng & Wright, 1994) and perceive more criticism from their parents (Chang, 1998). Another recent study found that AA college women reported greater parental expectations and criticism than their White counterparts, and that direct parental influence and indirect peer influence contributed to eating disturbances (Chang, Yu, & Lin, 2014). Hence, although disordered eating is often seen as stemming from overvaluing shape and weight, for AA women, it may also be shaped by their experience of navigating traditional Asian values and mainstream U.S. culture.

Generational Status

The common definition of generation centers on birthplace. Immigrants who are born outside of the United States are first generation, and their children the second, and so on. Some argue that the sociocultural characteristics and psychological experiences of those who immigrate to the United States as children are distinct from those who immigrated as adults (first generation) and those who are U.S. born with either immigrant parents (second generation) or U.S.-born parents (Kim, Brenner, Liang, & Asay, 2003; Park, 1999), and the term "1.5 generation" has been coined to represent this group. There has been some evidence suggesting that AAs who have close ties to countries of origin or family members who are more traditional may experience unique difficulties and distress during the process of negotiating between two cultures. For example, a study from a nationally representative sample found that the younger AA immigrants were when they moved to the United States, the greater their depression symptoms, and that their negative interactions with family and relatives further exacerbated the effects of acculturative stress on depression symptoms (Xu & Chi, 2013). Another study found that for first- and second-generation AA college students, individual acculturation did not predict distress; rather, it was those AA parents and children with

the greatest cultural differences that had the most family conflict and distress (Castillo, Zahn, & Cano, 2012). Castillo and her colleagues suggest that perhaps not all individuals experience acculturation to be as stressful as scholars on immigration have hypothesized, and that it is the family and community's reaction to the acculturating individual that most influences the resulting level of psychological distress (Castillo et al., 2012). More specifically related to disordered eating, therapists who worked with AA women observed that most of their clients were of first and second generation who experienced pressures from the dominant culture and the culture of origin (Smart et al., 2011). Therefore, this study examined generational status as a means of assessing the proximity of participants and their parents to their cultures of origin.

Purpose of the Study

Given the contradictory nature of the literature and limited empirical data on the role of cultural adaptation and socialization in AA women's disordered eating, the purpose of the present study was exploratory in nature. We sought to (a) examine of the role of traditional cultural beliefs and values in AA women with disordered eating and (b) examine if there were differences in disordered eating for AA women of different generational status.

Method

Participants

A total of 324 AA women responded to an online survey. After excluding those who did not respond to the disordered eating assessment (SCOFF, $n = 64$), and those whose age and body mass index (BMI) met the outlier analyses criteria ($n = 19$), the final sample size was 241. The largest ethnic group was Chinese (29.5%), followed by Vietnamese (19.9%), Taiwanese (14.5%), Korean, multiethnic (8.7% each), and Filipina (6.6%). Most of the participants identified as second generation (51.5%) and 1.5 generation (30.3%), followed by third generation and above (9.5%) and first (8.7%). Approximately 47% of the participants categorized themselves as middle class, followed by upper-middle class (28.6%), lower-middle class (15.4%), lower class (6.6%), and upper class (2.5%). Their average age was 28.5 years ($SD = 8.00$, ranging from 18 to 52). The average BMI (kg/m^2) was 21.78 ($SD = 2.74$, ranging from 15.79 to 29.47), with 76.3% in the BMI "normal" category, 12% "overweight," and 9.5% "underweight." Approximately 11% of the participants reported having had an ED in the past (assessed by a self-report question), but only one fourth of them sought treatment. Using the SCOFF, 21.3% ($n = 51$) of the participants met the screening criteria (answering "yes" to at least two of the items) for possible ED diagnoses (Hill, Reid, Morgan, & Lacey, 2010; Morgan, Reid, & Lacey, 1999).

Instruments

Generational status. Generational status was determined by self-report into the categories of first (born in another country and moved to the United States after the age of 12 years), 1.5 (were born in another country and moved to the United States before the age of 12 years), second (born in the United States and their parents were born in another country), and third and above generation (born in the United States, and their parents were born in the United States). This study categorizes individuals who immigrated before the age of 12 years as 1.5 generation (Rumbaut & Ima, 1988).

Disordered eating screening. Although there are several measures that have been widely used around the world, there is no measure to date that is entirely adequate for assessing EDs or disordered eating in AAs (Tsong & Smart, 2014). SCOFF (acronym corresponds with the five questions: S, sick/self-induced vomiting; C, control/fear of uncontrolled eating; O, one stone [14 pounds] body weight loss; F, fat/body image disturbance; F, food/domination over life), was developed as a simple, five-question screening tool for EDs to be used in primary care settings (Morgan et al., 1999). SCOFF addresses the core features of anorexia and bulimia as follows (U.S. version): (a) Do you make yourself sick/vomit because you feel uncomfortably full? (b) Do you worry you have lost control over how much you eat? (c) Have you recently lost more than 14 pounds in a 3-month period? (d) Do you believe yourself to be fat when others say you are too thin? and (e) Would you say that food dominates your life? Answering "yes" to two or more questions is the suggested cutoff for detecting EDs (Hill et al., 2010; Morgan et al., 1999). SCOFF was found to be a valid screening tool not only in ED clinics and student populations but also in general populations (Hill et al., 2010; Mond et al., 2008). SCOFF scores, rather than cutoff criteria, are used as an indicator of the level of disordered eating in this study (Mond et al., 2008). Higher numbers of "yes" answers indicate higher levels of disordered eating. The internal reliability of the SCOFF in this study was low (.56), although that is consistent with previous studies (Leung et al., 2009; Mond et al., 2008) and may be due to the small number of items (five) in SCOFF, the binary answer layout (yes/no; Siervo, Boschi, Papa, Bellini, & Falconi, 2005), and the distinct features of disordered eating that each of the items assesses.

Cultural beliefs. The AAVSM (Kim et al., 2005) was used to assess specific AA cultural values and beliefs. It consists of 42 items and 5 dimensions of traditional Asian values: Collectivism, Conformity to Norms, Emotional Self-Control, Family Recognition Through Achievement, and Humility, with coefficient αs ranging from .84 to .95 for AAs with acceptable discriminant and construct validity (Kim et al., 2005). In this study, coefficient αs were .80, .79, .84, .92, and .81.

Procedure

After institutional review board approval, a community sample of AA women was recruited using a snowball-sampling strategy via personal contact, professional listservs (e.g., Asian American Psychological Association, American Psychological Association Division 35 Section 5 Psychology of Asian Pacific American Women, American Psychological Association of Graduate students, etc.), and Facebook. Participants were asked to complete an online questionnaire for "a study on AA women's attitudes and views on a variety of topics, including relationships with family, satisfactions with themselves, etc.," and were provided an opportunity to participate in a raffle drawing of ten $25 cash prizes.

Results

Consistent with methodological recommendations for studying disordered eating in AAs (Cummins et al., 2005; Jung & Forbes, 2006) and this study's emphasis on AA women's disordered eating beyond its relationship with body size, BMI was controlled in the analyses.

Generational Status

A univariate analysis of covariance (ANCOVA) was conducted with SCOFF total scores as the criterion variable and generational status (four groups: first, 1.5, second, third and above) as the factor, with BMI as the controlled covariate. Results indicated that BMI was not a significant contributor to overall disordered eating, and with BMI being controlled, generational status was a significant factor, $F(3, 231) = 3.28$, $p = .022$, $\eta^2 = .041$. Post hoc mean comparisons revealed that second-generation AA women reported significantly higher overall disordered eating than their first-generation ($p = .015$) and third-generation ($p = .041$) counterparts (see Figure 1). See Table 1 for the SCOFF descriptive statistics by generational status.

Cultural Beliefs and Disordered Eating

A linear hierarchical regression analysis was conducted with the SCOFF total scores (0 to 5) as the criterion variable. BMI was entered in the first block as a control variable. Generational status was entered into block 2 using effect coding to further control the differences in disordered eating due to generational status. Effect coding was chosen because it allows for examinations of group mean in relation to overall sample mean (Cohen, Cohen, West, & Aiken, 2003). Finally, the five aspects of traditional Asian values (AAVSM subscales) were entered into block 3 to examine the effects of specific cultural beliefs on disordered eating, above and beyond the effects related to BMI and generational status. Table 2 summarizes the results.

Results revealed that BMI was not a significant factor in overall disordered eating. After controlling for BMI, generational status explained a significant 4.1% of the variance in disordered eating, *F Change* (3, 231) = 3.28, $p = .022$, with second-generation women reporting significantly higher levels of disordered eating than the overall mean of the sample. Next, above and beyond the differences due to BMI and generational status, two specific cultural values emerged as significant contributors of disordered eating: Family Recognition Through Achievement, $\beta = .18$, $p = .022$, and Emotional Self-Control, $\beta = .16$, $p = .035$, explaining a significant 5.8% of the variance in disordered eating, *F Change* (5, 226) = 2.89, $p = .015$.

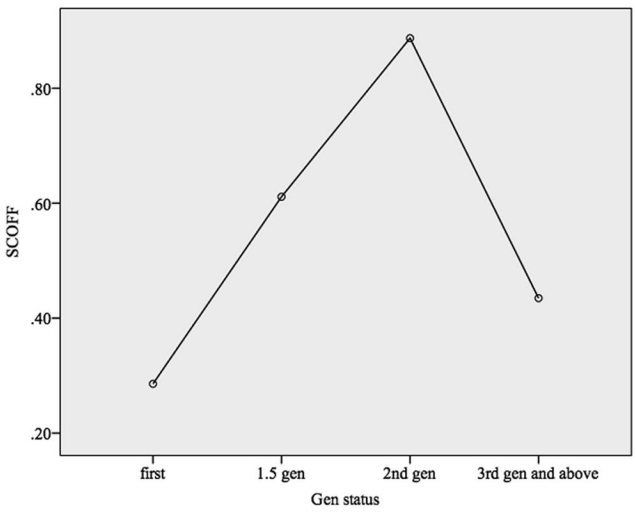

Figure 1. SCOFF by generational status.

Discussion

This exploratory study examined the degree to which generational status and cultural values and beliefs contributed to disordered eating in a diverse group of AA women, and we believe it adds to the extant literature regarding the cultural context of possible disordered eating risk factors.

BMI

Contrary to existing evidence on risk factors (Striegel-Moore & Bulik, 2007), BMI was not related to disordered eating in this sample. Although more research is needed, this may suggest that BMI is less useful as a risk factor for many AA women. What mainstream researchers and clinicians consider normal weight may not be perceived as slim enough in the context of AA culture. For example, therapists who work with AA women with disordered eating suggested that even very small amounts of weight gain in already slim women could create great distress because of perceived pressure from family and the belief that AA women were supposed to be ultra thin (Smart et al., 2011). Therefore, belief about body size may be more salient than the actual body size in AA women. Very little research has explored a cognitive etiological framework for disordered eating with AA women (Cummins et al., 2012). However, in a comparison of Japanese and mostly White U.S. college women, it was found that although the level of disordered eating was similar, the factors predicting it were different (Mukai, Kambara, & Sasaki, 1998). More specifically, although actual body fatness was predictive of disordered eating in the U.S. college women (90% White), it was body dissatisfaction and the need for social approval that were the predictive factors in the Japanese women's disordered eating. These results lend further support for examining the role of cultural values and beliefs in the context of AA women's disordered eating attitudes and behaviors.

Generational Status and Biculturative Stress

Results of this study seem to suggest that the experience of second-generation women is unique with regard to disordered eating as compared with first and third generations. Therapists working with AA women believed that those who are most actively negotiating with both "worlds" may experience double pressure by trying to meet the expectations from both the culture of origin and the U.S. mainstream culture about their physical attractiveness and professional achievements. Indeed, many of the therapists' clients visited their countries of origin regularly and contended with criticism on both fronts (Smart et al., 2011). The present study did not find any generational differences in cultural

Table 1
Means and Standard Deviations of SCOFF by Generational Status

	Overall		1st generation		1.5 generation		2nd generation		3rd and above	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
SCOFF	0.71	1.03	0.29	0.72	0.61	0.93	0.89	1.14	0.43	0.79

beliefs during the preliminary analyses, which suggests cultural beliefs and traditional values can be passed down from generation to generation, regardless of behavioral practices of the indigenous or dominant culture (e.g., language fluency, food and music preferences). The elevated risk level of second-generation AA women may suggest that it was not the Westernization or traditional cultural beliefs alone that put AA women at risk of disordered eating, but rather the double sets of cultural beliefs that they attempt to integrate and balance. It has been suggested that individuals who can effectively function in both the indigenous and dominant cultures may exhibit greater cognitive functioning and mental health (LaFromboise, Coleman, & Gerton, 1993), and those who are able to successfully meet the demands of two cultures have bicultural competence. On the other hand, biculturative stress can be defined as the stress arising out of navigating and negotiating both culture of origin and the host culture, particularly when one can identify with both. For the AA women in this study, stresses arising during the process of becoming biculturally competent, or biculturative stress, may be the factor that contributes to higher levels of disordered eating. This may offer some insights into the conflicting results in the current literature examining the role of "culture" or "acculturation" in AA women's disordered eating. If we understand the role of biculturative stress in disordered eating from the perspective of cultural conflicts in AA women's family/sociocultural environment, then simply examining the levels of acculturation may not offer enough information. As previously suggested, acculturation may not be as stressful if one's immediate sociocultural environment (e.g., family) reacts to the process with little conflict (Castillo et al., 2012). Similar results were found in previous studies with South Asian American women (Reddy & Crowther, 2007) and British-Asian women (Bryant-Waugh & Lask, 1991; A. J. Hill & Bhatti, 1995), suggesting that it might be the level of conflict in the sociocultural environment, rather than the behavioral acculturation of the individual, that was related to maladaptive eating attitudes (Reddy & Crowther, 2007).

Cultural Values and Disordered Eating

This study also examined the roles of specific traditional cultural beliefs and values in AA women's disordered eating behaviors and attitudes. Family Recognition Through Achievement and Emotional Self-Control emerged as the only two significant predictors.

Family recognition through achievement. Those who endorsed the belief that family's recognition is through achievement reported more disordered eating, even after taking BMI and generational status into consideration. The degree to which children believe they must live up to parental expectations has been linked to AA's emotional distress in general (Wang, 2010). Results from this study indicate that, more specifically, it may also be one of the more salient ways in which traditional values shape the experience of disordered eating in some AA women. For example, Kawamura (2011) asserted that the degree to which parental criticism may affect body dissatisfaction depends on whether the child perceives criticism and normative parental control in the context of support or disappointment. Ting and Hwang (2007) hypothesized that

Table 2
Statistics for the Linear Hierarchical Regression Models for Disordered Eating (SCOFF)

Variables	R^2	R^2 Change	*F Change*	β	*P*
Step 1: BMI	.003		.66	.05	.418
Step 2: Generational statuses are entered*		.041	3.28		.022
BMI				.06	.399
1st generation				−.11	.163
1.5 generation				.03	.646
2nd generation**				.22	.002
Step 3: Cultural values are entered*		.058	2.89		.015
BMI				.03	.680
1st generation				−.10	.175
1.5 generation				.02	.753
2nd generation**				.20	.004
Cultural beliefs					
Collectivism				−.05	.517
Conformity for Norms				−.07	.373
Emotional Self-Control*				.16	.035
Family Recognition Through Achievement*				.19	.022
Humility				.01	.905

Note. Generational status is entered using effect coding.
* $p < .05$. ** $p < .01$.

daughters who are more acculturated may not perceive the more traditional authoritarian parenting style as supportive, which can lead to further distress. Although the AAVSM subscale refers more commonly to "academic achievement," therapists who worked with AA women with disordered eating (Smart et al., 2011) reported that most of their clients perceived the need to please parents and achieve not only academically and professionally, but also in appearance (i.e., presenting oneself in a certain way), and that for some, the family's pride is linked to their children's professional achievement and appearance.

It was previously theorized that greater collectivism might provide a similar cultural influence for some AA women in the need to present well for the good of the family and community (Kawamura, 2002). However, this was not confirmed in the present study, and it is possible that the concept of collectivism may be too varied or broad to produce a direct correlation with disordered eating. Rather, achievement for the good of the family may in fact be more specific and relevant in AA women's disordered eating.

Emotional self-control. Some argue that the desire to not stand out or embarrass family and to adhere to social expectations would correlate with a need to manage one's appearance and body, becoming a risk for disordered eating (Kawamura, 2002; Smart et al., 2011). Therapists who work with this population reported that disordered eating was a way for their clients to cope (Smart et al., 2011), because these AA women may not have had the emotional language or did not feel it was permissible to express personal desires or disappointments in a direct manner. Results from the present study seem to further support the hypotheses that for AA women who believe in emotional self-control and covert expressions of desires or distress, disordered eating may serve a function. It is possibly a way to disconnect from emotions to conform to family demands and expectations, and it may provide a way to reduce distress from having conflicted personal desires. The research on self-silencing may also be useful in understanding this relationship. Silencing the self is the process by which a woman is deferential and compliant in interpersonal relationships for the sake of securing that relationship (Jack, 1991). It has been found to be associated with depression and poor psychological well-being in women (Jack & Ali, 2010; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991), and AA women were found to have significantly higher levels of self-silencing compared with Black, White, and Latina women (Gratch, Bassett, & Attra, 1995). This may lend further support for investigating the role of restricting emotional expression on the psychological well-being of AA women. Researchers also have begun to establish the connection between disordered eating and individuals' difficulties with processing emotions (e.g., Oldershaw et al., 2011). Therapists reported that AA women who showed improvements in their disordered eating learned the importance of setting boundaries with family as well as developing close relationships and intimacy outside of the family (Smart & Tsong, 2014). The importance of learning interpersonal skills and finding support that allows and promotes emotional connections and expressions may be particularly important in reducing the risks of disordered eating in AA women.

Limitations and Directions for Future Research

The results of this study must be interpreted in light of several limitations. Although second-generation AA women were identified as more at risk than their first- and third-generation (and above) counterparts, the group sizes for first and third generation and above were relatively smaller. Given the nature of the methodology, causation cannot be inferred, and indeed the results are quite preliminary. Because of the very complex etiology of EDs, cultural values need to be included in multifactorial models that demonstrate multiple risk pathways to disordered eating (and possible protective mechanisms as well). In addition, the use of the SCOFF measure for AA women is not yet well established; hence, the level of disordered eating risk in this study must be interpreted with caution. However, given that there are no well-validated disordered eating measures for AA women (Tsong & Smart, 2014), and that researchers have remained concerned that AA women's disordered eating symptomology goes undetected in studies with established but not culturally validated measures (Nicdao et al., 2007), we believe the SCOFF provides a potentially important avenue for evaluating risk for disordered eating in AA women. Finally, although the community sample was diverse in terms of age and the inclusion of several ethnic groups, most of the participants were of East Asian (Chinese, Taiwanese, Korean), Filipina, Vietnamese, and multiethnic heritages. Although there were no differences among the above ethnic groups in their overall disordered eating (based on the preliminary descriptive analyses), there were not enough participants of South Asian heritage (i.e., Indian, Pakistan, etc.) to assess the difference between them and the other groups. Therefore, comparison to studies conducted in the United Kingdom (e.g., Furnham & Adam-Saib, 2001; Mumford et al., 1991) should be done with caution.

Despite the limitations and preliminary nature of the study, we believe that it offers support for more exploration of cultural context in the risk for disordered eating in AA women in several ways: (a) second-generation AA women may have experiences that put them at risk for EDs, possibly because of the biculturative stresses of navigating two cultures and intergenerational stress; (b) the pressure, or perceived pressure to achieve, possibly including appearance achievement, may be a salient factor under certain circumstances; and (c) the use of disordered eating behaviors as a coping method to express distress in a covert manner may be particularly relevant for some AA women. Clinical or psychoeducational interventions that incorporate attention to cultural negotiations and interpretations may be beneficial for AA women. For example, therapists could help AA women better understand the implicit affection common in less acculturated parents and the support that is embedded in the direct, hierarchical, explicit criticism expressed by older family members (Ting & Hwang, 2007). Furthermore, therapists who are aware of the unique pressures on AA women to succeed within the contexts of Asian and mainstream U.S. cultures may be better able to form a therapeutic alliance and help their clients toward recovery.

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2014 Best Paper Award

Asian American Journal of Psychology

Each summer, the editorial board of the *Asian American Journal of Psychology* reviews all the papers published in the journal in the previous years and selects the winner of the Best Paper Award. The winner is recognized at the annual convention of the Asian American Psychological Association in August. We are proud to announce the winner of the 2014 AAJP Best Paper Award—**Arpana G. Inman, Lavanya Devdas, Valeriya Spektor, and Asmita Pendse** for their article "Psychological Research on South Asian Americans: A Three-Decade Content Analysis" (Volume 5, Number 4).

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