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# Family food and shape messages: Capturing the experiences of African-American women

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ABSTRACT

Four studies explored the family food experiences (FFEs) of African-American (AA) in relation to disordered eating and body image concerns. Focus groups of AA women expressed FFEs that shaped their relationships with food (Study 1). We used the resulting framework to create a measure assessing FFEs related to disordered eating (*Family Food Experiences-Black Questionnaire*; *FFBQ*). Measure items were subjected to a content analysis (Study 2). Subject matter experts rated ten items essential (CVR $\geq$ 0.62, $p < 0.05$). An exploratory factor analysis (EFA) was performed on the 10-item FFBQ in a sample of AA ($N = 66$) women (Study 3). The two-factor model explained 41.14% of the variance in the items ($X^2 = 25.04$, $df = 26$, $p = 0.52$. Finally, a confirmatory factor analysis (CFA) was performed on the FFBQ in a new sample of AA women ($N = 167$) to confirm the factor structure. The EFA yielded two subscales: a Traditional Thin-Ideal (TTI) and a Curvy Ideal (CI) subscale (reflecting messages that emphasize valuation of curves). These subscales were confirmed by CFA in a second sample of AA women with modifications to two items ($X^2 = 32.63$, $X^2/df = 2.04$). Disordered eating was positively correlated with messages reflecting both ideals while only messages reflecting the Curvy Ideal was related to body image disturbance. Implications include a need for further study of the duality of body ideal messages and the impact on body image/disordered eating disturbance in AA women.



## 1. Family food and shape messages: capturing the experiences of African-American

Prevalence rates for disordered eating and eating disorders among African-American (AA) women are similar to those found in White women (in general, we use AA but when others used the term Black and national origin was not reported, we will also use the term Black). For instance, the National Survey of American Life found lifetime prevalence rates of diagnosed eating disorders in AA women of 0.14% for anorexia and 1.9% for bulimia (Taylor, Caldwell, Baser, Faison, & Jackson, 2007), as compared to 0.9% for anorexia and 1.5% for bulimia in samples comprised of primarily White individuals (Hudson, Hiripi, Pope, & Kssler, 2007). Other studies yielded rates of up to 2% of AA women meeting the diagnostic criteria for an eating disorder at some time in their lives (Marques et al., 2011), compared to rates of 0.5% for anorexia and 1–3% for bulimia among women overall. Likewise, a study on disordered eating indicated that 23% of Black women were symptomatic (comparable to studies with White samples that yielded rates of 19–32%; Mulholland & Mintz, 2001). Although differences in body dissatisfaction have been found (often with AA or Black women being more satisfied, see Bruns & Carter, 2015; Franko & Roehrig, 2011; Jefferson & Stake, 2009), the size of the difference is small (e.g., Grabe & Hyde, 2006) and some studies reveal the majority of AA individuals also experience some level of body dissatisfaction (e.g., Jung & Forbes, 2012). In addition, AA women report that expectations for thinness also apply to them (Poran, 2006). These findings on prevalence rates and presence of body image and eating concerns in AA women indicate that disordered eating and body dissatisfaction are problems for AA women that require empirical study; however, research is often conducted on samples that are typically comprised of White women and girls (see Grabe & Hyde, 2006), which leaves the etiological factors in ethnic minorities understudied (Stojek & Fischer, 2013).

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### 1.1. Eating and body image disturbances in African-American women

Although eating and body image disturbances clearly affect AA women, the little research available suggests that the eating disturbances may not develop for the same reasons as those found in studies primarily comprised of White women. For example, AA women have been found to be less dissatisfied with their bodies, experience fewer negative evaluations about their bodies, compare themselves less to media images, have less concern about weight loss, and make less of an effort to achieve weight loss than their White counterparts (Abrams, Allen, & Gray, 1992; Jefferson & Stake, 2009; Petersons, Rojhani, Steinhaus, & Larkin, 2000; Roberts, Cash, Feingold, & Johnson, 2006; Warren, 2014; Wilfley et al., 1996). Additionally, AA women have been shown to prefer larger body shape ideals than White and Latina women, suggesting that perhaps the pursuit of the traditional "thin body ideal" may not be as prevalent for AA women (e.g., Chen & Wang, 2012; Gordon, Castro, Sitnikov, & Holm-Denoma, 2010). As such, it may be necessary to examine risk factors for eating disorders among AA women in ways that allow for the emergence of cultural differences that may exist in the etiology and experience of these psychological problems.

### 1.2. Family influence on disordered eating and body dissatisfaction

Although the factors that contribute to the development of eating and body image disturbances are numerous, some of the potential risk factors are more likely to be influenced by cultural experiences than others. Indeed, research has demonstrated that cultural factors (e.g., access to westernized media) can influence the emergence and appearance of eating disturbances (see Becker, Burwell, Gilman, Herzog, & Hamburg, 2002). Yet, other cultural factors seem to serve more protective roles (e.g., Rubin, Fitts, & Becker, 2003).

The family environment is one area where cultural differences may directly operate. Cross-cultural researchers have encouraged the examination of cultural differences in the family-of-origin values and practices (Kane & Erdman, 1998), and researchers have noted cultural differences in the effects that family influence has on body dissatisfaction in the development of anorexic and bulimic symptoms (Quiles Marcos, Quiles Sebastián, Pamies Aubalat, Botella Ausina, & Treasure, 2013). Additionally, research on eating disturbances has linked family environments that emphasize thinness and appearance with disordered eating in predominantly White populations (Eisenberg, Berge, Fulkerson, & Neumark-Sztainer, 2012; Kluck, 2008, 2010; Young, Clopton, & Bleckley, 2004). For example, Kluck (2008) found that parental comments (e.g., teasing, criticism) about weight and size and maternal modeling of disordered eating and body dissatisfaction (based on daughters' perceptions and recall of behaviors while growing up) was related to disordered eating in college-aged daughters. In addition, in a longitudinal study of mother-daughter dyads Francis and Birch (2005) found that mothers who reported they were more preoccupied with their own weight concerns also reported that they encouraged their pre-adolescent daughters to lose weight more often, which was related to perceived pressure to lose weight and restrained eating in daughters. In these studies, women and girls who experienced more criticism and teasing from parents had higher rates of disordered eating and body dissatisfaction. Researchers have also found that parents of individuals with eating disturbances were more likely to exhibit problematic eating attitudes and behaviors themselves (Striegel-Moore et al., 2005). We refer to these aspects of family influence as negative family food-related experiences (FFEs).

Despite the potential for negative FFEs to be heavily grounded in culture, a review of the literature on disordered eating in AA women yielded few studies that examined familial roles in the development of these symptoms with this population (Tyler, 2003). In those studies that do examine family roles in the development of disordered eating in AA girls and women, the studies either focused on development of obesity (e.g., Davis, Rovi, & Johnson, 2005), emphasized relational or demographic factors (e.g., abuse, attachment, parental income and occupation; Harris, 1995; Maresh & Willard, 1996; Sira & Ballard, 2009), or included a include a subset of participants who identified as AA women without including examination of potential similarities and differences for AA women (e.g., Kluck, 2008; Mellin, Neumark-Sztainer, Patterson, & Sockalosky, 2004; Palmberg et al., 2014). As Tyler (2003) noted, the lack of research in this domain is problematic due to the roles of family and food in AA culture. In one of the few studies that look at links between mother and daughter eating behaviors in AA individuals, caloric intake of mothers was correlated with caloric intake of daughters (Reed, Dancy, Holm, Wilbur, & Fogg, 2012). Moreover, the limited available research suggests that families may provide protective and body positive messages for some AA women (e.g., family support for having larger body sizes, emphasizing cultural practices around food over size; Capodilupo & Kim, 2014), which is consistent with the notion that families may be a means through which cultural messages about body weight/shape are communicated to young women and girls.

In response to the limited research available on negative FFEs in AA women, we thought it important to qualitatively explore the specific FFEs reported by AA women and the similarities and differences between FFEs found with predominately White women and the qualitative report of AA women. Our approach focused on allowing within-culture values to represent the starting point for a measure such that we were able to develop and evaluate a culturally-relevant measure of negative FFEs in AA women.

## 2. Grounded theory design: a cultural approach

To achieve our purposes and consistent with a recommendation for mixed methods research to better understand the complexity of body dissatisfaction concerns in AA women (see Franko & Roehrig, 2011), it was important to begin with a qualitative-cultural approach. Much of the current work regarding AA women and disordered eating has utilized a comparison approach in which researchers examine how AA women relate to White women on already established predictors and measures of disordered eating. Although this is a valid approach, its drawback is the assumption that we can adequately extract a portrait of the familial influences of disordered eating for an understudied population from an established model and holds one cultural group as the central group to which we compare others. We potentially ignore variables that may be relevant in FFEs of AA women which have not been found relevant (or studied) in the FFEs of White women. For example, racial socialization (e.g., family activities that expose youth to ethnic history) has not been a major focus of exploring risk and protective factors for disordered eating in White women. However, racial socialization in the family was found to be important as a protective factor for AA adolescent girls with a larger body size when examining risk for development of poor self-image (Granberg, Gordon Simons, & Simons, 2009), illustrating one drawback of the comparison approach that emphasizes already established predictors. Similarly, Poran (2006) suggested that the omnipresent emphasis on weight, which is consistently important in research on disordered eating with White women, has been used without question or verification of the appropriateness of this approach.