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Thinness and restricting expectancies mediate the influence of ethnic identity on bulimic symptoms

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ABSTRACT

Studies suggest that a developed sense of ethnic identity is associated with positive psychological outcomes, but the relationship between ethnic identity (EI) and symptoms of bulimia nervosa (BN) is not clear. We tested a model that thinness expectancies mediate the relationship between EI and BN symptoms. We hypothesized that (1) EI would be negatively correlated with thinness expectancies and BN symptoms; (2) thinness expectancies would be positively correlated with BN symptoms; and (3) thinness expectancies would mediate the relationship between EI and BN symptoms.

Four hundred ninety-three college women from diverse ethnic backgrounds completed self-report measures of thinness expectancies, ethnic identity, and bulimic symptoms.

EI accounted for significant variance in BN symptoms ($beta = -.10$, $p < .05$) and thinness expectancies ($beta = -.12$, $p < .01$). Thinness expectancies accounted for significant variance in BN symptoms ($beta = .61$, $p < .01$). Results of a hierarchical linear regression were consistent with the posited hypothesis. Results suggest that EI may be a factor in developing BN symptoms in minority as well as non-minority women. It may be that an individual with a strong sense of belonging to a certain ethnic group is less likely to develop thinness expectancies and consequently BN symptoms.

1. Introduction

Researchers and clinicians are increasingly aware of the impact of ethnicity and identification with race on psychopathology and health, as the population of the United States and Europe is growing more diverse (Franko, Becker, Thomas, & Herzog, 2007; Hooghe, Trappers, Meuleman, & Reeskens, 2008). A growing body of literature suggests that ethnic minority women experience disordered eating symptoms at similar rates to Caucasian women, despite stereotypes to the contrary (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Polivy, Herman, & Boivin, 2004; Shaw, Ramirez, Trost, Randall, & Stice, 2004). A sense of belongingness and affiliation with one's ethnic group is associated with lower psychopathology in both non-White and White individuals (Roberts et al., 1999). Thus, a well developed sense of ethnic identity may contribute to better mental health, including resilience against eating disorders. The purpose of this study is to examine the relationship of ethnic identity to bulimic (BN) symptoms in a diverse sample of young adult women, and to test a model by which overgeneralized positive expectancies for thinness and restriction mediate the relationship between ethnic identity and BN symptoms.

2. Ethnic Identity

Ethnic identity (EI) is considered part of social identity, in that individuals tend to identify with a certain group and have value judgments related to their membership in the group (Tajfel, 1981). In ethnically diverse countries, race or ethnic group is a salient aspect of this social identity. The formation of *ethnic* identity specifically occurs in a diverse society where two or more cultural groups are in contact for an extended period of time (Phinney, 1990). Thus, individuals of any racial background can develop ethnic identity (EI).

Ethnic identity may be more easily defined by the constructs that it is not rather than what it is. EI formation is not synonymous with acculturation (Phinney, Horenczyk, Liebkind, & Vedder, 2001). Acculturation describes how the minority group relates to the dominant group (Berry, 1997) whereas EI focuses on how an individual relates to his or her own group (Phinney, 1990). EI is also not equivalent with ethnicity (Phinney et al., 2001) which refers to subgroups within a larger society that identify with the same ancestry and share elements such as culture, religion, or language, among others (Hutchinson & Smith, 1996). Ethnicity may also be conceptualized as an ascribed feature that is perceived by others, whereas EI includes individuals' self-concept, self-identification and the feeling of belonging and commitment to a certain group (Liebkind, 1992; Phinney & Ong, 2007). Thus, EI is not exclusive

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to individuals of ethnic minorities. The assessment of EI comprises exploration of one's ethnic group, commitment to that group, and self-identification with an ethnic label that one uses to describe oneself (Phinney & Ong, 2007; Roberts et al., 1999; Singh, 1977).

Researchers have found that higher levels of EI are positively correlated with self-esteem, self-confidence, psychological well-being, and even engagement with academia across ethnic groups (e.g., Martinez & Dukes, 1997; Phinney, Cantu, & Kurtz, 1997; Shin, Daly, & Vera, 2007). EI also appears to be negatively correlated with distress. For example, loneliness and depression were negatively correlated with ethnic identity in a sample of African Americans and Caucasians, and appears to act as a buffer from distress after the experience of discrimination in Chinese samples (Roberts et al., 1999; Yip, Gee, & Takeuchi, 2008). This and other studies also reported that symptoms such as suicidal ideation, feelings of worthlessness, and anxiety were negatively correlated with ethnic identity (Martinez & Dukes, 1997; Phinney & Chavira, 1992; Roberts et al., 1999). These findings suggest that individuals with a stronger sense of EI may have increased resilience to psychopathology.

3. Bulimia nervosa and ethnic identity

Bulimia Nervosa (BN) is characterized by binge eating followed by inappropriate compensatory behaviors, such as laxative use or self-induced vomiting, as well as attaching distorted value to weight and body shape (APA, 2000). Identified risk factors for BN include internalization of the thin ideal presented in mainstream media and restrictive dieting behavior to achieve that ideal (Stice, 2002). It has become clear that symptoms of BN are experienced by individuals with a range of diverse ethnicities (Cachelin et al., 2001; Crago, Shisslak, & Estes, 1996; Shaw et al., 2004). Moreover, some researchers have concluded that there are few ethnic differences in eating disturbances and risk factors for developing them (Shaw et al., 2004). For example, frequency of eating disorder symptoms does not seem to differ by racial groups, but expression of symptoms, such as method of purging, may vary (Franko et al., 2007).

There are very few studies that examine the influence of ethnic identity on disordered eating symptoms in diverse samples of women, despite the fact that it is associated with positive mental health outcomes. Many studies simply compare two or more different racial groups on a variety of outcome measures associated with BN symptoms, or examine the influence of immigration status, not EI, on eating disorders. For example, a comparison of White, Black, Hispanic, and Asian women in the US found similar rates of binge eating and dieting in these groups (Le Grange, Stone, & Brownell, 1998). Some studies comparing Black and White women in the US also did not find significant differences in disordered eating between the two groups (Cachelin & Regan, 2006; Reagan & Hersch, 2005). A study of Hispanic females in the US found that internalization of Western sociocultural norms was associated with greater willingness to risk one's health to lose weight (Blow, Taylor, Cooper, & Redfearn, 2010). Studies of adolescent females of diverse ethnicities in Europe indicate that African and Asian immigrants experience ED symptoms, and that this may be associated with conflicts between their culture of origin and Western European cultural norms (Bhugra & Bhui, 2003; McCourt & Waller, 1996). One study of adolescents in immigrant families in the US found that having parents born in the US was positively associated with ED status, but did not assess EI or level of affiliation with parent culture (Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000). While these studies are informative, the influence of EI in all participants was not assessed. Additionally, many studies which assess acculturation use indicators such as the primary language spoken by the participant or count of years lived in the adopted country, not a self-report of identification with one's own ethnic group.

4. Thinness and restricting expectancies

Expectancies may be described as the "summaries of individuals' learning experiences" (Smith, Simmons, Flory, Annus, & Hill, 2007, p. 189). Expectancy theory proposes that individuals' learning histories lead them to develop expectancies of the consequences of behaviors; consequently, expectancies affect their future choices (MacCorquodale & Meehl, 1953). Thus, individuals are more likely to pursue behaviors from which they expect rewards and avoid behaviors from which they expect punishment. Expectancies can develop from direct or indirect learning experiences. Expectancy theory has been applied to a number of psychological phenomena, including eating disorders (Smith et al., 2007). In this context, some individuals learn to expect strong reinforcers from dieting and thinness, and they are more likely to pursue maladaptive means to thinness (Hohlstein, Smith, & Atlas, 1998). Learning experiences that shape these expectancies can be maternal or peer modeling of dieting and ED behavior or internalization of ideals about thinness and dieting presented in media (Annus, Smith, & Masters, 2008).

The reinforcers expected from being thin and restricting food intake fall into the broad category of "overgeneralized self-improvement" (Hohlstein et al., 1998, p. 52). Individuals expect to feel more capable, more self-confident and more respected by others as a result of being thin (Hohlstein et al., 1998). Prospective and experimental studies have found that thinness expectancies predict subsequent bulimic behaviors in adolescent girls and young adult women (Annus et al., 2008; Smith et al., 2007). Additionally, thinness expectancies have the same relationship to BN symptoms in both Black and Caucasian women (Atlas, Smith, Hohlstein, McCarthy, & Kroll, 2002). As suggested previously (Bhugra & Bhui, 2003; McCourt & Waller, 1996), women who do not feel a strong sense of belonging to a particular cultural group may be more likely to exhibit disordered eating. We hypothesize that it may be because they are more likely to internalize mainstream values regarding appearance and self worth. Thus, they may be more likely to endorse positive expectancies for self-improvement from thinness and restricting, which in turn may influence BN symptoms.

5. Current study and hypotheses

Recent research suggests that ethnic minority and Caucasian women experience BN symptoms at similar rates. As both white and non-White women in Western culture are exposed to sociocultural factors that contribute to disordered eating formation such as pressure to be thin and thin ideal internalization, they are likely to develop thinness expectancies; overgeneralized expectations of the positive consequences resulting from the achievement of the unrealistic thin ideal. High levels of EI appear to contribute to higher self-esteem and lower psychopathology, in both White and non-White samples. Thus, it is plausible that women with high levels of EI may have avenues with which to pursue self worth other than appearance. As thinness expectancies encompass a range of expectations for self-improvement, such as feeling confident and respected by others (Hohlstein et al., 1998), it is possible that individuals with higher levels of belonging to an ethnic group feel less pressure to be thin and to espouse those expectancies, which consequently leads to lower bulimic symptoms. This can occur even when an individual has a similar skin color to that which is most consistently presented in mainstream media. For example,