"A WAY OUTA NO WAY": Eating Problems among African-American, Latina, and White Women

BECKY WANGSGAARD THOMPSON
Princeton University

This article offers a feminist theory of eating problems (anorexia, bulimia, extensive dieting, and binging) based on life history interviews with African-American, Latina, and white women. Until recently, research on eating problems has focused on white middle- and upper-class heterosexual women. While feminist research has established why eating problems are gendered, an analysis of how race, class, and sexual oppression are related to the etiology of eating problems has been missing. The article shows that eating problems begin as strategies for coping with various traumas including sexual abuse, racism, classism, sexism, heterosexism, and poverty. Identifying eating problems as survival strategies shifts the focus from portraying them as issues of appearance to ways women take care of themselves as they cope with trauma.

Bulimia, anorexia, binging, and extensive dieting are among the many health issues women have been confronting in the last 20 years. Until recently, however, there has been almost no research about eating problems among African-American, Latina, Asian-American, or Native American women, working-class women, or lesbians.[1] In fact, according to the normative epidemiological portrait, eating problems are largely a white, middle-, and upper-class heterosexual phenomenon. Further, while feminist research has documented how eating problems are fueled by sexism, there has been almost no attention to how other systems of oppression may also be implicated in the development of eatingproblems.

AUTHOR'S NOTE: *The research for this study was partially supported by an American Association of University Women Fellowship in Women's Studies. An earlier version of this article was presented at the New England Women's Studies Association Meeting in 1990 in Kingston, Rhode Island. I am grateful to Margaret Andersen, Liz Bennett, Lynn Davidman, Mary Gilfus, Evelynn Hammonds, and two anonymous reviewers for their comprehensive and perceptive comments on earlier versions of this article.*

REPRINT REQUESTS: *Becky Wangsgaard Thompson, Afro-American Studies Program, 112 Dickinson Hall, Princeton University, Princeton, NJ 08544-1017.*

GENDER & SOCIETY, Vol. 6 No. 4, December 1992 546-561

In this article, I reevaluate the portrayal of eating problems as issues of appearance based in the "culture of thinness." I propose that eating problems begin as ways women cope with various traumas including sexual abuse, racism, classism, sexism, heterosexism, and poverty. Showing the interface between these traumas and the onset of eating problems explains why women may use eating to numb pain and cope with violations to their bodies. This theoretical shift also permits an understanding of the economic, political, social, educational, and cultural resources that women need to change their relationship to food and their bodies.

EXISTING RESEARCH ON EATING PROBLEMS

There are three theoretical models used to explain the epidemiology, etiology, and treatment of eating problems. The biomedical model offers important scientific research about possible physiological causes of eating problems and the physiological dangers of purging and starvation (Copeland 1985; Spack 1985). However, this model adopts medical treatment strategies that may disempower and traumatize women (Garner 1985; Orbach 1985). In addition, this model ignores many social, historical, and cultural factors that influence women's eating patterns. The psychological model identifies eating problems as "multidimensional disorders" that are influenced by biological, psychological, and cultural factors (Garfinkel and Garner 1982). While useful in its exploration of effective therapeutic treatments, this model, like the biomedical one, tends to neglect women of color, lesbians, and working-class women.

The third model, offered by feminists, asserts that eating problems are gendered. This model explains why the vast majority of people with eating problems are women, how gender socialization and sexism may relate to eating problems, and how masculine models of psychological development have shaped theoretical interpretations. Feminists offer the culture of thinness model as a key reason why eating problems predominate among women. According to this model, thinness is a culturally, socially, and economically enforced requirement for female beauty. This imperative makes women vulnerable to cycles of dieting, weight loss, and subsequent weight gain, which may lead to anorexia and bulimia (Chernin 1981; Orbach 1978, 1985; Smead 1984).

Feminists have rescued eating problems from the realm of individual psychopathology by showing how the difficulties are rooted in systematic and pervasive attempts to control women's body sizes and appetites. However, researchers have yet to give significant attention to how race, class, and sexuality influence women's understanding of their bodies and appetites. The handful of epidemiological studies that include African-American women

and Latinas casts doubt on the accuracy of the normative epidemiological portrait. The studies suggest that this portrait reflects which particular populations of women have been studied rather than actual prevalence (Andersen and Hay 1985; Gray, Ford, and Kelly 1987; Hsu 1987; Nevo 1985; Silber 1986).

More important, this research shows that bias in research has consequences for women of color. Tomas Silber (1986) asserts that many well-trained professionals have either misdiagnosed or delayed their diagnoses of eating problems among African-American and Latina women due to stereotypical thinking that these problems are restricted to white women. As a consequence, when African-American women or Latinas are diagnosed, their eating problems tend to be more severe due to extended processes of starvation prior to intervention. In her autobiographical account of her eating problems, Retha Powers (1989), an African-American woman, describes being told not to worry about her eating problems since "fat is more acceptable in the Black community" (p. 78). Stereotypical perceptions held by her peers and teachers of the "maternal Black woman" and the "persistent mammy-brickhouse Black woman image" (p. 134) made it difficult for Powers to find people who took her problems with food seriously.

Recent work by African-American women reveals that eating problems often relate to women's struggles against a "simultaneity of oppression" (Clarke 1982; Naylor 1985; White 1991). Byllye Avery (1990), the founder of the National Black Women's Health Project, links the origins of eating problems among African-American women to the daily stress of being undervalued and overburdened at home and at work. In Evelyn C. White's (1990) anthology, *The Black Woman's Health Book: Speaking for Ourselves*, Georgiana Arnold (1990) links her eating problems partly to racism and racial isolation during childhood.

Recent feminist research also identifies factors that are related to eating problems among lesbians (Brown 1987; Dworkin 1989; Iazzetto 1989; Schoenfielder and Wieser 1983). In her clinical work, Brown (1987) found that lesbians who have internalized a high degree of homophobia are more likely to accept negative attitudes about fat than are lesbians who have examined their internalized homophobia. Autobiographical accounts by lesbians have also indicated that secrecy about eating problems among lesbians partly reflects their fear of being associated with a stigmatized illness ("What's Important" 1988).

Attention to African-American women, Latinas, and lesbians paves the way for further research that explores the possible interface between facing multiple oppressions and the development of eating problems. In this way, this study is part of a larger feminist and sociological research agenda that seeks to understand how race, class, gender, nationality, and sexuality inform women's experiences and influence theory production.

METHODOLOGY

I conducted 18 life history interviews and administered lengthy questionnaires to explore eating problems among African-American, Latina, and white women. I employed a snowball sample, a method in which potential respondents often first learn about the study from people who have already participated. This method was well suited for the study since it enabled women to get information about me and the interview process from people they already knew. Typically, I had much contact with the respondents prior to the interview. This was particularly important given the secrecy associated with this topic (Russell 1986; Silberstein, Striegel-Moore, and Rodin 1987), the necessity of women of color and lesbians to be discriminating about how their lives are studied, and the fact that I was conducting across-race research.

To create analytical notes and conceptual categories from the data, I adopted Glaser and Strauss's (1967) technique of theoretical sampling, which directs the researcher to collect, analyze, and test hypotheses during the sampling process (rather than imposing theoretical categories onto the data). After completing each interview transcription, I gave a copy to each woman who wanted one. After reading their interviews, some of the women clarified or made additions to the interview text.

Demographics of the Women in the Study

The 18 women I interviewed included 5 African-American women, 5 Latinas, and 8 white women. Of these women, 12 are lesbian and 6 are heterosexual. Five women are Jewish, 8 are Catholic, and 5 are Protestant. Three women grew up outside of the United States. The women represented a range of class backgrounds (both in terms of origin and current class status) and ranged in age from 19 to 46 years old (with a median age of 33.5 years).

The majority of the women reported having had a combination of eating problems (at least two of the following: bulimia, compulsive eating, anorexia, and/or extensive dieting). In addition, the particular types of eating problems often changed during a woman's life span. (For example, a woman might have been bulimic during adolescence and anorexic as an adult.) Among the women, 28 percent had been bulimic, 17 percent had been bulimic and anorexic, and 5 percent had been anorexic. All of the women who had been anorexic or bulimic also had a history of compulsive eating and extensive dieting. Of the women, 50 percent were compulsive eaters and dieters (39 percent) or compulsive eaters (11 percent) but had not been bulimic or anorexic.

Two-thirds of the women have had eating problems for more than half of their lives, a finding that contradicts the stereotype of eating problems as transitory. The weight fluctuation among the women varied from 16 to 160

pounds, with an average fluctuation of 74 pounds. This drastic weight change illustrates the degree to which the women adjusted to major changes in body size at least once during their lives as they lost, gained, and lost weight again. The average age of onset was 11 years old, meaning that most of the women developed eating problems prior to puberty. Almost all of the women (88 percent) consider themselves as still having a problem with eating, although the majority believe they are well on the way to recovery.

THE INTERFACE OF TRAUMA AND EATING PROBLEMS

One of the most striking findings in this study was the range of traumas the women associated with the origins of their eating problems, including racism, sexual abuse, poverty, sexism, emotional or physical abuse, heterosexism, class injuries, and acculturation.[2] The particular constellation of eating problems among the women did not vary with race, class, sexuality, or nationality. Women from various race and class backgrounds attributed the origins of their eating problems to sexual abuse, sexism, and emotional and/or physical abuse. Among some of the African-American and Latina women, eating problems were also associated with poverty, racism, and class injuries. Heterosexism was a key factor in the onset of bulimia, compulsive eating, and extensive dieting among some of the lesbians. These oppressions are not the same nor are the injuries caused by them. And certainly, there are a variety of potentially harmful ways that women respond to oppression (such as using drugs, becoming a workaholic, or committing suicide). However, for all these women, eating was a way of coping with trauma.

Sexual Abuse

Sexual abuse was the most common trauma that the women related to the origins of their eating problems. Until recently, there has been virtually no research exploring the possible relationship between these two phenomena. Since the mid-1980s, however, researchers have begun identifying connections between the two, a task that is part of a larger feminist critique of traditional psychoanalytic symptomatology (DeSalvo 1989; Herman 1981; Masson 1984). Results of a number of incidence studies indicate that between one-third and two-thirds of women who have eating problems have been abused (Oppenheimer et al. 1985; Root and Fallon 1988). In addition, a growing number of therapists and researchers have offered interpretations of the meaning and impact of eating problems for survivors of sexual abuse (Bass and Davis 1988; Goldfarb 1987; Iazzetto 1989; Swink and Leveille 1986). Kearney-Cooke (1988) identifies dieting and binging as common ways in which women cope with frequent psychological consequences of

sexual abuse (such as body image disturbances, distrust of people and one's own experiences, and confusion about one's feelings). Root and Fallon (1989) specify ways that victimized women cope with assaults by binging and purging: bulimia serves many functions, including anesthetizing the negative feelings associated with victimization. Iazzetto's innovative study (1989), based on in-depth interviews and art therapy sessions, examines how a woman's relationship to her body changes as a consequence of sexual abuse. Iazzetto discovered that the process of leaving the body (through progressive phases of numbing, dissociating and denying) that often occurs during sexual abuse parallels the process of leaving the body made possible through binging.

Among the women I interviewed, 61 percent were survivors of sexual abuse (11 of the 18 women), most of whom made connections between sexual abuse and the beginning of their eating problems. Binging was the most common method of coping identified by the survivors. Binging helped women "numb out" or anesthetize their feelings. Eating sedated, alleviated anxiety, and combated loneliness. Food was something that they could trust and was accessible whenever they needed it. Antonia (a pseudonym) is an Italian-American woman who was first sexually abused by a male relative when she was four years old. Retrospectively, she knows that binging was a way she coped with the abuse. When the abuse began, and for many years subsequently, Antonia often woke up during the middle of the night with anxiety attacks or nightmares and would go straight to the kitchen cupboards to get food. Binging helped her block painful feelings because it put her back to sleep.

Like other women in the study who began binging when they were very young, Antonia was not always fully conscious as she binged. She described eating during the night as "sleep walking. It was mostly desperate—like I had to have it." Describing why she ate after waking up with nightmares, Antonia said, "What else do you do? If you don't have any coping mechanisms, you eat." She said that binging made her "disappear," which made her feel protected. Like Antonia, most of the women were sexually abused before puberty; four of them before they were five years old. Given their youth, food was the most accessible and socially acceptable drug available to them. Because all of the women endured the psychological consequences alone, it is logical that they coped with tactics they could do alone as well.

One reason Antonia binged (rather than dieted) to cope with sexual abuse is that she saw little reason to try to be the small size girls were supposed to be. Growing up as one of the only Italian Americans in what she described as a "very WASP town," Antonia felt that everything from her weight and size to having dark hair on her upper lip were physical characteristics she was supposed to hide. From a young age she knew she "never embodied the essence of the good girl. I don't like her. I have never acted like her. I can't

be her. I sort of gave up." For Antonia, her body was the physical entity that signified her outsider status. When the sexual abuse occurred, Antonia felt she had lost her body. In her mind, the body she lived in after the abuse was not really hers. By the time Antonia was 11, her mother put her on diet pills. Antonia began to eat behind closed doors as she continued to cope with the psychological consequences of sexual abuse and feeling like a cultural outsider.

Extensive dieting and bulimia were also ways in which women responded to sexual abuse. Some women thought that the men had abused them because of their weight. They believed that if they were smaller, they might not have been abused. For example when Elsa, an Argentine woman, was sexually abused at the age of 11, she thought her chubby size was the reason the man was abusing her. Elsa said, "I had this notion that these old perverts liked these plump girls. You heard adults say this too. Sex and flesh being associated." Looking back on her childhood, Elsa believes she made fat the enemy partly due to the shame and guilt she felt about the incest. Her belief that fat was the source of her problems was also supported by her socialization. Raised by strict German governesses in an upper-class family, Elsa was taught that a woman's weight was a primary criterion for judging her worth. Her mother "was socially conscious of walking into places with a fat daughter and maybe people staring at her." Her father often referred to Elsa's body as "shot to hell." When asked to describe how she felt about her body when growing up, Elsa described being completely alienated from her body. She explained,

> Remember in school when they talk about the difference between body and soul? I always felt like my soul was skinny. My soul was free. My soul sort of flew. I was tied down by this big bag of rocks that was my body. I had to drag it around. It did pretty much what it wanted and I had a lot of trouble controlling it. It kept me from doing all the things that I dreamed of.

As is true for many women who have been abused, the split that Elsa described between her body and soul was an attempt to protect herself from the pain she believed her body caused her. In her mind, her fat body was what had "bashed in her dreams." Dieting became her solution, but, as is true for many women in the study, this strategy soon led to cycles of binging and weight fluctuation.

Ruthie, a Puerto Rican woman who was sexually abused from 12 until 16 years of age, described bulimia as a way she responded to sexual abuse. As a child, Ruthie liked her body. Like many Puerto Rican women of her mother's generation, Ruthie's mother did not want skinny children, interpreting that as a sign that they were sick or being fed improperly. Despite her mother's attempts to make her gain weight, Ruthie remained thin through puberty. When a male relative began sexually abusing her, Ruthie's sense of

her body changed dramatically. Although she weighed only 100 pounds, she began to feel fat and thought her size was causing the abuse. She had seen a movie on television about Romans who made themselves throw up and so she began doing it, in hopes that she could look like the "little kid" she was before the abuse began. Her symbolic attempt to protect herself by purging stands in stark contrast to the psychoanalytic explanation of eating problems as an "abnormal" repudiation of sexuality. In fact, her actions and those of many other survivors indicate a girl's logical attempt to protect herself (including her sexuality) by being a size and shape that does not seem as vulnerable to sexual assault.

These women's experiences suggest many reasons why women develop eating problems as a consequence of sexual abuse. Most of the survivors "forgot" the sexual abuse after its onset and were unable to retrieve the abuse memories until many years later. With these gaps in memory, frequently they did not know why they felt ashamed, fearful, or depressed. When sexual abuse memories resurfaced in dreams, they often woke feeling upset but could not remember what they had dreamed. These free floating, unexplained feelings left the women feeling out of control and confused. Binging or focusing on maintaining a new diet were ways women distracted or appeased themselves, in turn, helping them regain a sense of control. As they grew older, they became more conscious of the consequences of these actions. Becoming angry at themselves for binging or promising themselves they would not purge again was a way to direct feelings of shame and self-hate that often accompanied the trauma.

Integral to this occurrence was a transference process in which the women displaced onto their bodies painful feelings and memories that actually derived from or were directed toward the persons who caused the abuse. Dieting became a method of trying to change the parts of their bodies they hated, a strategy that at least initially brought success as they lost weight. Purging was a way women tried to reject the body size they thought was responsible for the abuse. Throwing up in order to lose the weight they thought was making them vulnerable to the abuse was a way to try to find the body they had lost when the abuse began.

Poverty

Like sexual abuse, poverty is another injury that may make women vulnerable to eating problems. One woman I interviewed attributed her eating problems directly to the stress caused by poverty. Yolanda is a Black Cape Verdean mother who began eating compulsively when she was 27 years old. After leaving an abusive husband in her early 20s, Yolanda was forced to go on welfare. As a single mother with small children and few financial resources, she tried to support herself and her children on $539 a month.

Yolanda began binging in the evenings after putting her children to bed. Eating was something she could do alone. It would calm her, help her deal with loneliness, and make her feel safe. Food was an accessible commodity that was cheap. She ate three boxes of macaroni and cheese when nothing else was available. As a single mother with little money, Yolanda felt as if her body was the only thing she had left. As she described it,

> I am here, [in my body] 'cause there is no where else for me to go. Where am I going to go? This is all I got . that probably contributes to putting on so much weight cause staying in your body, in your home, in yourself, you don't go out. You aren't around other people . You hide and as long as you hide you don't have to face nobody can see you eat. You are safe.

When she was eating, Yolanda felt a momentary reprieve from her worries. Binging not only became a logical solution because it was cheap and easy but also because she had grown up amid positive messages about eating. In her family, eating was a celebrated and joyful act. However, in adulthood, eating became a double-edged sword. While comforting her, binging also led to weight gain. During the three years Yolanda was on welfare, she gained seventy pounds.

Yolanda's story captures how poverty can be a precipitating factor in eating problems and highlights the value of understanding how class inequalities may shape women's eating problems. As a single mother, her financial constraints mirrored those of most female heads of households. The dual hazards of a race- and sex-stratified labor market further limited her options (Higginbotham 1986). In an article about Black women's health, Byllye Avery (1990) quotes a Black woman's explanation about why she eats compulsively. The woman told Avery,

> I work for General Electric making batteries, and, I know it's killing me. My old man is an alcoholic. My kid's got babies. Things are not well with me. And one thing I know I can do when I come home is cook me a pot of food and sit down in front of the TV and eat it. And you can't take that away from me until you're ready to give me something in its place. (P. 7)

Like Yolanda, this woman identifies eating compulsively as a quick, accessible, and immediately satisfying way of coping with the daily stress caused by conditions she could not control. Connections between poverty and eating problems also show the limits of portraying eating problems as maladies of upper-class adolescent women.

The fact that many women use food to anesthetize themselves, rather than other drugs (even when they gained access to alcohol, marijuana, and other illegal drugs), is partly a function of gender socialization and the competing demands that women face. One of the physiological consequences of binge eating is a numbed state similar to that experienced by drinking. Troubles and tensions are covered over as a consequence of the body's defensive

response to massive food intake. When food is eaten in that way, it effectively works like a drug with immediate and predictable effects. Yolanda said she binged late at night rather than getting drunk because she could still get up in the morning, get her children ready for school, and be clearheaded for the college classes she attended. By binging, she avoided the hangover or sickness that results from alcohol or illegal drugs. In this way, food was her drug of choice since it was possible for her to eat while she continued to care for her children, drive, cook, and study. Binging is also less expensive than drinking, a factor that is especially significant for poor women. Another woman I interviewed said that when her compulsive eating was at its height, she ate breakfast after rising in the morning, stopped for a snack on her way to work, ate lunch at three different cafeterias, and snacked at her desk throughout the afternoon. Yet even when her eating had become constant, she was still able to remain employed. While her patterns of eating no doubt slowed her productivity, being drunk may have slowed her to a dead stop.

Heterosexism

The life history interviews also uncovered new connections between heterosexism and eating problems. One of the most important recent feminist contributions has been identifying compulsory heterosexuality as an institution which truncates opportunities for heterosexual and lesbian women (Rich 1986). All of the women interviewed for this study, both lesbian and heterosexual, were taught that heterosexuality was compulsory, although the versions of this enforcement were shaped by race and class. Expectations about heterosexuality were partly taught through messages that girls learned about eating and their bodies. In some homes, boys were given more food than girls, especially as teenagers, based on the rationale that girls need to be thin to attract boys. As the girls approached puberty, many were told to stop being athletic, begin wearing dresses, and watch their weight. For the women who weighed more than was considered acceptable, threats about their need to diet were laced with admonitions that being fat would ensure becoming an "old maid."

While compulsory heterosexuality influenced all of the women's emerging sense of their bodies and eating patterns, the women who linked heterosexism directly to the beginning of their eating problems were those who knew they were lesbians when very young and actively resisted heterosexual norms. One working-class Jewish woman, Martha, began compulsively eating when she was 11 years old, the same year she started getting clues of her lesbian identity. In junior high school, as many of her female peers began dating boys, Martha began fantasizing about girls, which made her feel utterly alone. Confused and ashamed about her fantasies, Martha came home every day from school and binged. Binging was a way she

drugged herself so that being alone was tolerable. Describing binging, she said, "It was the only thing I knew. I was looking for a comfort." Like many women, Martha binged because it softened painful feelings. Binging sedated her, lessened her anxiety, and induced sleep.

Martha's story also reveals ways that trauma can influence women's experience of their bodies. Like many other women, Martha had no sense of herself as connected to her body. When I asked Martha whether she saw herself as fat when she was growing up she said, "I didn't see myself as fat. I didn't see myself. I wasn't there. I get so sad about that because I missed so much." In the literature on eating problems, *body image* is the term that is typically used to describe a woman's experience of her body. This term connotes the act of imagining one's physical appearance. Typically, women with eating problems are assumed to have difficulties with their body image. However, the term body image does not adequately capture the complexity and range of bodily responses to trauma experienced by the women. Exposure to trauma did much more than distort the women's visual image of themselves. These traumas often jeopardized their capacity to consider themselves as having bodies at all.

Given the limited connotations of the term body image, I use the term *body consciousness* as a more useful way to understand the range of bodily responses to trauma.[3] By body consciousness I mean the ability to reside comfortably in one's body (to see oneself as embodied) and to consider one's body as connected to oneself. The disruptions to their body consciousness that the women described included leaving their bodies, making a split between their body and mind, experiencing being "in" their bodies as painful, feeling unable to control what went in and out of their bodies, hiding in one part of their bodies, or simply not seeing themselves as having bodies. Binging, dieting, or purging were common ways women responded to disruptions to their body consciousness.

Racism and Class Injuries

For some of the Latinas and African-American women, racism coupled with the stress resulting from class mobility related to the onset of their eating problems. Joselyn, an African-American woman, remembered her white grandmother telling her she would never be as pretty as her cousins because they were lighter skinned. Her grandmother often humiliated Joselyn in front of others, as she made fun of Joselyn's body while she was naked and told her she was fat. As a young child, Joselyn began to think that although she could not change her skin color, she could at least try to be thin. When Joselyn was young, her grandmother was the only family member who objected to Joselyn's weight. However, her father also began encouraging his wife and daughter to be thin as the family's class standing began to change. When the

family was working class, serving big meals, having chubby children, and keeping plenty of food in the house was a sign the family was doing well. But, as the family became mobile, Joselyn's father began insisting that Joselyn be thin. She remembered, "When my father's business began to bloom and my father was interacting more with white businessmen and seeing how they did business, suddenly thin became important. If you were a truly well-to-do family, then your family was slim and elegant."

As Joselyn's grandmother used Joselyn's body as territory for enforcing her own racism and prejudice about size, Joselyn's father used her body as the territory through which he channeled the demands he faced in the white-dominated business world. However, as Joselyn was pressured to diet, her father still served her large portions and bought treats for her and the neighborhood children. These contradictory messages made her feel confused about her body. As was true for many women in this study, Joselyn was told she was fat beginning when she was very young even though she was not overweight. And, like most of the women, Joselyn was put on diet pills and diets before even reaching puberty, beginning the cycles of dieting, compulsive eating, and bulimia.

The confusion about body size expectations that Joselyn associated with changes in class paralleled one Puerto Rican woman's association between her eating problems and the stress of assimilation as her family's class standing moved from poverty to working class. When Vera was very young, she was so thin that her mother took her to a doctor who prescribed appetite stimulants. However, by the time Vera was eight years old, her mother began trying to shame Vera into dieting. Looking back on it, Vera attributed her mother's change of heart to competition among extended family members that centered on "being white, being successful, being middle class, . . . and it was always, 'Ay Bendito. She is so fat. What happened?'"

The fact that some of the African-American and Latina women associated the ambivalent messages about food and eating to their family's class mobility and/or the demands of assimilation while none of the eight white women expressed this (including those whose class was stable and changing) suggests that the added dimension of racism was connected to the imperative to be thin. In fact, the class expectations that their parents experienced exacerbated standards about weight that they inflicted on their daughters.

EATING PROBLEMS AS SURVIVAL STRATEGIES

Feminist Theoretical Shifts

My research permits a reevaluation of many assumptions about eating problems. First, this work challenges the theoretical reliance on the culture-

of-thinness model. Although all of the women I interviewed were manipulated and hurt by this imperative at some point in their lives, it is not the primary source of their problems. Even in the instances in which a culture of thinness was a precipitating factor in anorexia, bulimia, or binging, this influence occurred in concert with other oppressions.

Attributing the etiology of eating problems primarily to a woman's striving to attain a certain beauty ideal is also problematic because it labels a common way that women cope with pain as essentially appearance-based disorders. One blatant example of sexism is the notion that women's foremost worry is about their appearance. By focusing on the emphasis on slenderness, the eating problems literature falls into the same trap of assuming that the problems reflect women's "obsession" with appearance. Some women were raised in families and communities in which thinness was not considered a criterion for beauty. Yet, they still developed eating problems. Other women were taught that women should be thin, but their eating problems were not primarily in reaction to this imperative. Their eating strategies began as logical solutions to problems rather than problems themselves as they tried to cope with a variety of traumas.

Establishing links between eating problems and a range of oppressions invites a rethinking of both the groups of women who have been excluded from research and those whose lives have been the basis of theory formation. The construction of bulimia and anorexia as appearance-based disorders is rooted in a notion of femininity in which white middle- and upper-class women are portrayed as frivolous, obsessed with their bodies, and overly accepting of narrow gender roles. This portrayal fuels women's tremendous shame and guilt about eating problems—as signs of self-centered vanity. This construction of white middle- and upper-class women is intimately linked to the portrayal of working-class white women and women of color as their opposite: as somehow exempt from accepting the dominant standards of beauty or as one step away from being hungry and therefore not susceptible to eating problems. Identifying that women may binge to cope with poverty contrasts the notion that eating problems are class bound. Attending to the intricacies of race, class, sexuality, and gender pushes us to rethink the demeaning construction of middle-class femininity and establishes bulimia and anorexia as serious responses to injustices.

Understanding the link between eating problems and trauma also suggests much about treatment and prevention. Ultimately, their prevention depends not simply on individual healing but also on changing the social conditions that underlie their etiology. As Bernice Johnson Reagon sings in Sweet Honey in the Rock's song "Oughta Be a Woman," "A way outa no way is too much to ask/too much of a task for any one woman" (Reagon 1980).[4] Making it possible for women to have healthy relationships with their bodies and eating is a comprehensive task. Beginning steps in this direction include

insuring that (1) girls can grow up without being sexually abused, (2) parents have adequate resources to raise their children, (3) children of color grow up free of racism, and (4) young lesbians have the chance to see their reflection in their teachers and community leaders. Ultimately, the prevention of eating problems depends on women's access to economic, cultural, racial, political, social, and sexual justice.

NOTES

1. I use the term *eating problems* as an umbrella term for one or more of the following: anorexia, bulimia, extensive dieting, or binging. I avoid using the term eating disorder because it categorizes the problems as individual pathologies, which deflects attention away from the social inequalities underlying them (Brown 1985). However, by using the term *problem* I do not wish to imply blame. In fact, throughout, I argue that the eating strategies that women develop begin as logical solutions to problems, not problems themselves.

2. By trauma I mean a violating experience that has long-term emotional, physical, and/or spiritual consequences that may have immediate or delayed effects. One reason the term *trauma* is useful conceptually is its association with the diagnostic label Post Traumatic Stress Disorder (PTSD) (American Psychological Association 1987). PTSD is one of the few clinical diagnostic categories that recognizes social problems (such as war or the Holocaust) as responsible for the symptoms identified (Trimble 1985). This concept adapts well to the feminist assertion that a woman's symptoms cannot be understood as solely individual, considered outside of her social context, or prevented without significant changes in social conditions.

3. One reason the term *consciousness* is applicable is its intellectual history as an entity that is shaped by social context and social structures (Delphy 1984; Marx 1964). This link aptly applies to how the women described their bodies because their perceptions of themselves as embodied (or not embodied) directly relate to their material conditions (living situations, financial resources, and access to social and political power).

4. Copyright © 1980. Used by permission of Songtalk Publishing.

REFERENCES

American Psychological Association. 1987. *Diagnostic and statistical manual of mental disorders*. 3rd ed. rev. Washington, DC: American Psychological Association.

Andersen, Arnold, and Andy Hay. 1985. Racial and socioeconomic influences in anorexia nervosa and bulimia. *International Journal of Eating Disorders* 4:479-87.

Arnold, Georgiana. 1990. Coming home: One Black woman's journey to health and fitness. In *The Black women's health book: Speaking for ourselves*, edited by Evelyn C. White. Seattle, WA: Seal Press.

Avery, Byllye Y. 1990. Breathing life into ourselves: The evolution of the National Black Women's Health Project. In *The Black women's health book: Speaking for ourselves*, edited by Evelyn C. White. Seattle, WA: Seal Press.

Bass, Ellen, and Laura Davis. 1988. *The courage to heal: A guide for women survivors of child sexual abuse*. New York: Harper & Row.

Brown, Laura S. 1985. Women, weight and power: Feminist theoretical and therapeutic issues. *Women and Therapy* 4:61-71.

——— 1987. Lesbians, weight and eating: New analyses and perspectives. In *Lesbian psychologies*, edited by the Boston Lesbian Psychologies Collective. Champaign: University of Illinois Press.

Chernin, Kim. 1981. *The obsession: Reflections on the tyranny of slenderness*. New York: Harper & Row.

Clarke, Cheryl. 1982. *Narratives*. New Brunswick, NJ: Sister Books.

Copeland, Paul M. 1985. Neuroendocrine aspects of eating disorders. In *Theory and treatment of anorexia nervosa and bulimia: Biomedical sociocultural and psychological perspectives*, edited by Steven Wiley Emmett. New York: Brunner/Mazel.

Delphy, Christine. 1984. *Close to home: A materialist analysis of women's oppression*. Amherst: University of Massachusetts Press.

DeSalvo, Louise. 1989. *Virginia Woolf: The impact of childhood sexual abuse on her life and work*. Boston, MA: Beacon.

Dworkin, Sari H. 1989. Not in man's image: Lesbians and the cultural oppression of body image. In *Loving boldly: Issues facing lesbians*, edited by Ester D. Rothblum and Ellen Cole. New York: Harrington Park Press.

Garfinkel, Paul E., and David M. Garner. 1982. *Anorexia nervosa: A multidimensional perspective*. New York: Brunner/Mazel.

Garner, David. 1985. Iatrogenesis in anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders* 4:701-26.

Glaser, Barney G., and Anselm L. Strauss. 1967. *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine DeGruyter.

Goldfarb, Lori. 1987. Sexual abuse antecedent to anorexia nervosa, bulimia and compulsive overeating: Three case reports. *International Journal of Eating Disorders* 6:675-80.

Gray, James, Kathryn Ford, and Lily M. Kelly. 1987. The prevalence of bulimia in a Black college population. *International Journal of Eating Disorders* 6:733-40.

Herman, Judith. 1981. *Father-daughter incest*. Cambridge, MA: Harvard University Press.

Higginbotham, Elizabeth. 1986. We were never on a pedestal: Women of color continue to struggle with poverty, racism and sexism. In *For crying out loud*, edited by Rochelle Lefkowitz and Ann Withorn. Boston: MA: Pilgrim Press.

Hsu, George. 1987. Are eating disorders becoming more common in Blacks? *International Journal of Eating Disorders* 6:113-24.

Iazzetto, Demetria. 1989. When the body is not an easy place to be: Women's sexual abuse and eating problems. Ph.D. diss., Union for Experimenting Colleges and Universities, Cincinnati, Ohio.

Kearney-Cooke, Ann. 1988. Group treatment of sexual abuse among women with eating disorders. *Women and Therapy* 7:5-21.

Marx, Karl. 1964. *The economic and philosophic manuscripts of 1844*. New York: International.

Masson, Jeffrey. 1984. *The assault on the truth: Freud's suppression of the seduction theory*. New York: Farrar, Strauss & Giroux.

Naylor, Gloria. 1985. *Linden Hills*. New York: Ticknor & Fields.

Nevo, Shoshana. 1985. Bulimic symptoms: Prevalence and ethnic differences among college women. *International Journal of Eating Disorders* 4:151-68.

Oppenheimer, R., K. Howells, R. L. Palmer, and D. A. Chaloner. 1985. Adverse sexual experience in childhood and clinical eating disorders: A preliminary description. *Journal of Psychiatric Research* 19:357-61.

Orbach, Susie. 1978. *Fat is a feminist issue*. New York: Paddington.

——— 1985. Accepting the symptom: A feminist psychoanalytic treatment of anorexia nervosa. In *Handbook of psychotherapy for anorexia nervosa and bulimia*, edited by David M. Garner and Paul E. Garfinkel. New York: Guilford.

Powers, Retha. 1989. Fat is a Black women's issue. *Essence*, Oct., 75, 78, 134, 136.

Reagon, Bernice Johnson. 1980. Oughta be a woman. On Sweet Honey in the Rock's album, *Good News*. Music by Bernice Johnson Reagon; lyrics by June Jordan. Washington, DC: Songtalk.

Rich, Adrienne. 1986. Compulsory heterosexuality and lesbian existence. In *Blood, bread and poetry*. New York: Norton.

Root, Maria P. P., and Patricia Fallon. 1988. The incidence of victimization experiences in a bulimic sample. *Journal of Interpersonal Violence* 3:161-73.

——— 1989. Treating the victimized bulimic: The functions of binge-purge behavior. *Journal of Interpersonal Violence* 4:90-100.

Russell, Diana E. 1986. *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Schoenfielder, Lisa, and Barbara Wieser, eds. 1983. *Shadow on a tightrope: Writings by women about fat liberation*. Iowa City, IA: Aunt Lute Book Co.

Silber, Tomas. 1986. Anorexia nervosa in Blacks and Hispanics. *International Journal of Eating Disorders* 5:121-28.

Silberstein, Lisa, Ruth Striegel-Moore, and Judith Rodin. 1987. Feeling fat: A woman's shame. In *The role of shame in symptom formation*, edited by Helen Block Lewis. Hillsdale, NJ: Lawrence Erlbaum.

Smead, Valerie. 1984. Eating behaviors which may lead to and perpetuate anorexia nervosa, bulimarexia, and bulimia. *Women and Therapy* 3:37-49.

Spack, Norman. 1985. Medical complications of anorexia nervosa and bulimia. In *Theory and treatment of anorexia nervosa and bulimia: Biomedical sociocultural and psychological perspectives*, edited by Steven Wiley Emmett. New York: Brunner/Mazel.

Swink, Kathy, and Antoinette E. Leveille. 1986. From victim to survivor: A new look at the issues and recovery process for adult incest survivors. *Women and Therapy* 5:119-43.

Trimble, Michael. 1985. Post-traumatic stress disorder: History of a concept. In *Trauma and its wake: The study and treatment of post-traumatic stress disorder*, edited by C. R. Figley. New York: Brunner/Mazel.

What's important is what you look like. 1988. *Gay Community News*, July, 24-30.

White, Evelyn C., ed. 1990. *The Black women's health book: Speaking for ourselves*. Seattle, WA: Seal Press.

——— 1991. Unhealthy appetites. *Essence*, Sept., 28, 30.

Becky Wangsgaard Thompson is a Rockefeller Foundation Fellow in the Afro-American Studies Program at Princeton University for 1992-1993. She has written on antiracist, feminist teaching methods and is completing a book on eating problems among African-American, Latina, and white women. Her edited anthology (with Sangeeta Tyagi), which consolidates progressive perspectives on multicultural education, is forthcoming.