

CLASSIC

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# 1 1 Cultural Obsessions with Thinness: African American, Latina, and White Women

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*According to the American Anorexia/Bulimia Association, 7 million women and 1 million men, ages ten to early twenties, suffer from eating disorders. An estimated 1,000 women die from anorexia every year. From an early age, girls are bombarded with messages that being thin will make them popular and happy and will attract a successful man. In this selection, Becky W. Thompson challenges the widely accepted belief that eating problems are largely limited to white, middle- and upper-class, heterosexual women. Instead of assuming that women are anorexic and bulimic because we live in a “culture of thinness,” Thompson argues, eating problems may also be a response to poverty, sexual abuse, racism, heterosexism, social class inequality, and acculturation.*

## 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 & 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.

*Source:* Becky W. Thompson, “A Way Outa No Way: Eating Problems among African American, Latina, and White Women,” pp. 52–69, in Esther Ngan-Ling Chow, Doris Wilkinson, and Maxine Baca Zinn, eds. *Race, Class & Gender: Common Bonds, Different Voices*. Copyright © 1996 by Sage Publications, Inc. Reprinted by permission of Sage Publications, Inc.

This imperative makes women vulnerable to cycles of dieting, weight loss, and subsequent weight gain, which may lead to anorexia nervosa 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 (Anderson & Hay, 1985; Gray, Ford, & 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 oppressions" (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 & 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 eighteen 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. . . .

### Demographics of the Women in the Study

The eighteen women I interviewed included five African American women, five Latinas, and

eight white women. Of these women, twelve are lesbian and six are heterosexual. Five women are Jewish, eight are Catholic, and five 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 nineteen to forty-six 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 nervosa, and/or extensive dieting). In addition, the particular types of eating problems often changed during a woman's life span. . . .

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 eleven years old, meaning that most of the women developed eating problems prior to puberty. Almost all of the women (88 percent) considered themselves as still having a problem with eating, although the majority believed they were 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.<sup>1</sup> 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 & 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 & Davis, 1988; Goldfarb, 1987; Iazzetto, 1989; Swink & Leveille, 1986). . . .

Among the women I interviewed, 61 percent were survivors of sexual abuse (eleven of the eighteen 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 bingeing 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. Bingeing helped her block painful feelings because it put her back to sleep.

Like other women in the study who began bingeing when they were very young, Antonia was not always fully conscious as she bingeed. She described eating during the night as “sleepwalking. 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 bingeing 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 use alone as well.

One reason Antonia bingeed (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 eleven, 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 eleven, 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 bingeing and weight fluctuation.

Ruthie, a Puerto Rican woman who was sexually abused from twelve until sixteen 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 one hundred 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. . . .

### **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 twenties, 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 bingeing 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, bingeing 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 quotes a Black woman's explanation about why she eats compulsively (1990:7). 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 kids 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.

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. . . .

### 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 eleven 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. . . .

### **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**

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 bingeing, 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 nervosa 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 nervosa as serious responses to injustices.

## CRITICAL-THINKING QUESTIONS

1. How do the biomedical, psychological, and feminist models differ in explaining eating disorders?
2. Why does Thompson argue that eating problems are survival strategies to cope with sexism; heterosexism; and emotional, sexual, or physical abuse?
3. Thompson maintains that women's eating problems are a response to poverty, racism, acculturation, and social class inequality. How, then, might we explain the low rates of eating disorders among Black, ethnic, and low-income men?

## NOTE

1. 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.

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