HEAVY WEIGHTS: AN EXPLORATION OF EMOTIONAL LINKAGES TO OVEREATING AND OBESITY IN AFRICAN AMERICAN WOMEN

by

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(Under the Direction of Patricia Bell-Scott)

ABSTRACT

There is little research on eating disorders and African Americans; at the same time health issues associated with these disorders are having an increasing impact on this population, especially women. This is an in-depth qualitative study of the emotional linkages to disordered eating that lead to obesity in African American women[1]. A comprehensive examination of the literature on the historical, cultural and social aspects of disordered eating in African American women is included as a foundation to understanding the multifaceted aspects of the problem. Relevant theoretical frameworks included Ecological Systems Theory, Black Feminist Thought, and the Biopsychosocial Model. Seven women provided lengthy accounts of their experiences gaining weight, overeating and living with obesity. The research findings indicated that women had distorted body images, used to food as a coping tool, and experienced stress related to role strain.

INDEX WORDS: African American women, obesity, overweight, overeating, qualitative, narrative analysis

[1] Women born in the US of black-skinned African descent.

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DEDICATION

This dissertation is dedicated to my family. It is dedicated to my husband, Victor Martin Kulkosky, my constant gardener, who watered the seed of my dream and encouraged every effort until it came to fruition. It is also dedicated to my children, Gregory Badí Earl Kulkosky, my son, and Alyson Simone-Nicole Allen, my niece and adopted daughter. Their sacrificial efforts (moving, changing schools, making new and missing old friends) were greatly appreciated.

It is dedicated to the *Strong Black Women* of my family, my mother and my "other mothers," who taught me the value of knowledge and learning, and modeled success for me. They include, in memory, my mother, Alyce Earl Rittenhouse, my grandmother, Maude Earl, my aunt, Doris Earl Harper, and Gwendolyn Earl, my aunt who departed this earthly plane my first day of graduate school. It is dedicated to my aunts, Bettye Earl McCoy and Gladys Earl Roberts, who saw me through this process with unwavering support, and my sister, Shanta Rittenhouse.

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TABLE OF CONTENTS

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER I

INTRODUCTION

It is not surprising that in America, a country of plenty, overeating and obesity have reached epidemic proportions. It also is not surprising that emotions are linked to eating, since feasting is integral to socially significant occasions, such as anniversaries, holidays, births and deaths. Specific foods are associated with particular cultural and ethnic group experiences (Poe, 1999) and overindulgence in these foods can lead to obesity. While factors such as metabolism, illness, physical limitations, and psychological disorders can affect weight gain, the most common reasons for being overweight are overeating and sedentary lifestyle (Croft, Strogatz, & Sherman, 1992; Dortch, 1997).

African American women are more challenged by the consequences of overeating, such as weight gain, high blood pressure, and diabetes, than any other group in this country (Collins & Winkleby, 2002; Kumanyika, 1994; Rosenberg, Palmer & Adams-Campbell, 1998). Overeating, leading to obesity and its associated health problems, has been linked with eating disturbance (Avery, 1990; Lovejoy, 2001; Thompson, 1992; White, 1991). There have been numerous studies on eating disorders, but most have focused on middle class White women (Gordon, Perez & Joiner, 2002; Kempa & Thomas, 2001). Moreover, when African American females have been studied, the focus has been on physical health issues rather than the emotional and contextual factors that lead to overeating and obesity (Brunner & Boyington, 2002; Davis, Clance, & Galis, 1999; Kaul & Nidiry, 1999; Stolley & Fitzgibbon, 1997). This gap in the literature highlights the need for studies that reflect multiple aspects of the obesity problem.

In this study I examined those cultural and emotional factors that lead to and sustain obesity in African American women. It is also my hope that the findings will lead to useful applications in the practice and treatment of obesity specific to African American women.

Purpose Statement

The purpose of this study was to describe and examine the emotional linkages to obesity and overeating in African American women. In Chapter Two, I reviewed the literature on obesity as a physical health concern, and then discussed the ways emotional and mental components have been tied to disordered eating. I situated disordered eating and its byproduct, obesity, within the historical, cultural and social contexts that have influenced behaviors that foster and maintain the problem in African American women. In Chapter Three, I described theoretical perspectives that provided helpful frameworks for understanding the phenomena. My methodological process and the participants are described in Chapter Four. From the interviews and analysis of the transcripts I created individual narratives of each participant; these narratives are found in Chapter Five. I summarize and discuss my findings in Chapter Six. The study is completed with an outline of implications for future research and practice in Chapter Seven.

Given the magnitude of the obesity problem among African American women, and the lack of research on eating disorders in this population, a study of this nature can lead to a more holistic approach to what has become a life-threatening problem to 50% of African American women (Collins & Winkleby, 2002, Kumanyika, 1994; Rosenberg, Palmer & Adams-Campbell, 1998).

Operational Definitions

The terms overweight, obesity, emotional stress, and overeating are central to this research effort. The following definitions were used for the purpose of this study:

1. Overweight: having a body mass index (a calculation, based on weight and height, of an individual's body fat) of 25-29.
2. Obesity: having a body mass index (BMI) of 30 or greater.
3. Emotional stress: feelings associated with strain, pressure, or traumatic events.
4. Overeating: eating beyond the point of satiation.

Research questions

This study was guided by three fundamental questions:

1. How do African American women describe the experience of being overweight?
2. What is the relationship between emotional stress and overeating in African American women?
3. What life experiences impact the outcome of obesity in African American women?

CHAPTER II
REVIEW OF THE LITERATURE

> *It's just been a series of temporary successes and then defeats -- various weight loss programs, up and down I'll get frustrated I quit, I'll get motivated I start. It's like you go up and down, in a cycle with motivation and frustration. I feel defeated by it many times, depressed about not being able to wear things, not being able to fit places*
>
> (Earl- Kulkosky, 2003).

In this chapter, I discuss the literature on the increase of obesity in America, the statistics related to women, particularly African American women, and the related health concerns. I discuss the ways emotional factors have been tied to disordered eating and compare this to the experiences of African American women with overeating. I situate disordered eating and its byproduct, obesity, within the historical, cultural and social contexts that have influenced behaviors that foster and maintain the problem in African American women.

The number of overweight people in the United States is rising (Blumenthal, Hendi & Marsillo, 2002; Dortch, 1997; Tilghman, 2003). One-fourth of American women are overweight (Gore, 2001) and, while being overweight is a health concern for American women, current findings (Collins & Winkleby, 2002; Jacobsen, Stevens, Kumanyika, & Keil, 1994) indicate that more than half of all African American women are overweight. Many are obese and morbidly obese (Gore 2002; Dortch, 1997).

Obesity is defined as having a body mass index (BMI) of 30 or greater (Bianchini, Kaaks & Vianio, 2002). Increasing health concerns associated with obesity indicate that it is a problem that has reached epidemic proportions since the mid-1980's (Croft, Strogatz, & Sherman, 1992; Dortch, 1997). Mokdad, et al. (2001) reported that obesity rates have increased by 61% between

1991 and 2000. When compared with White women, rates of obesity are two times greater for African American women and Hispanic women (Adderly-Kelly & Williams-Stephens, 2003).

The physiological factors, such as increased consumption of fatty foods and decreased physical activity, that lead to and maintain obesity have been studied (Bianchini, Kassks & Vianio, 2002; Kumanyika, 2001). The diseases associated with obesity are well documented (Adderly-Kelly & Williams-Stephen, 2003; Banks-Wallace, 2002; Rosenberg, Palmer, Adams-Campbell & Rao, 1998; Tilghman, 2003). For instance, hypertension and diabetes are commonly associated with obesity; both diseases are more prevalent among African American women (Adderly-Kelly & Williams-Stephen, 2003; Banks-Wallace, 2002; Dortch, 1997; Kumanyika, 1994; Tilghman, 2003). African American women have a life expectancy five years less than that of White women largely due to high death rates from heart disease, breast cancer, diabetes, and cardiovascular disease (Adderly-Kelly & Williams-Stephen, 2003; Kumanyika, Morssink, & Nestle, 2001). The consequences of obesity and its related illnesses are clear. What remains unknown is where the disconnect lies between knowledge and behavioral change.

The definition of eating disorders includes disturbances in eating behavior such as eating too much, not eating enough, or eating in an extremely unhealthy manner (American Psychiatric Association, 1994). Eating disorders include anorexia-self-induced starvation, bulimia-binge eating followed by self-induced vomiting, and binge eating disorder-eating large amounts of food in a discrete period of time (American Psychiatric Association, 1994). Overeating is a component of both bulimia and binge eating.

Eating disorders are often associated with body dissatisfaction and societal standards of beauty (Kempa & Thomas, 2002). Treatment has focused on understanding the emotions and mental distress that lead to eating disorders. Most psychotherapeutic treatment is commonly

targeted to young European American females (Thompson, 1992). Behavior management strategies have been developed to assist African American women to make the connection between knowledge and behavior, but much of the focus remains on obesity as a physical health concern (Avery, 1990; Bronner & Boyington, 2002; Davis et al, 1999; Kaul & Nidiry, 1999; Stolley & Fitzgibbon, 1997).Research is limited on the linkages between emotional factors associated with overeating in African American women. Thompson (1992) suggested that eating disorders in African American women might be associated with internalized oppression stemming from the experience of racism. Feelings of anger and powerlessness and a stressful environment, are associated with the experiences of racial discrimination (Kempa & Thomas, 2000).

African American women health activists Byllye Avery, founder of the National Black Women's Health Project, and Evelyn White (1991) editor of the anthology, *The Black Woman's Health Book: Speaking for Ourselves*, link the origin of eating disturbance to the pile-up of stressors associated with gender and racial oppression. Avery (1990) found in her self-help groups for obese African American women that knowledge of health risks was no substitute for the comfort food provided participants struggling to exist in a world that does not see them. One woman spoke of the stress of her job, spouse and children.

> Things are not well with me. And the 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 unless you are ready to give me something in its place (Avery 1990, p.7).

Stressors that African American women face include a decline of spousal and family support, high divorce rates, an increase in single-parent families, and limits on time and money (McAdoo, 1998; Tucker & Mitchell-Kernan, 1995). Time limitations make fast food choices

inviting. While a combination of these stressors is associated with poverty, and a number of obese African American women have low income, those women with high income and advanced education represent a significant segment of overweight African American women (Kumanyika, 1997). These women confront cultural expectations to "be strong" and available to family and community (Banks-Wallace, 2000; Gore, 1999; hooks, 1993; Root, 1990). High stress, coupled with social and family gatherings that connect love and comfort with particular foods, may be the key to understanding the development of obesity among African American women. The challenge to researchers, then, is to seek or develop theoretical frameworks that consider the multidimensional nature of eating disorders for this population.

Disordered Eating: Historical Contributions

Disordered eating is defined as patterns of eating that may or may not lead to full blown eating disorders; the line is somewhat arbitrary, as behaviors that are a part of disordered eating are also a part of eating disorders (Health News, 2000). These behaviors include diet or exercise patterns that lead to extremes in body size. The most commonly recognized eating disorders are anorexia and bulimia (Kempa & Thomas, 2002). Anorexia is described as a complex emotional disorder characterized by obsessive behavior (e.g., excessive exercise and dieting) around food and weight; bulimia is characterized by overeating and then purging through self-induced vomiting or the use of laxatives (Killian, 1994; Tyler, 2003). Both disorders involve deprivation that can lead to extreme weight reduction.

For many African American women, disordered eating is characterized by the over consumption of fatty foods, the notable absence of healthy foods, and a lack of exercise -- all of which can lead to obesity (Banks-Wallace, 2000; Blumenthal, Hendi, & Marsillo, 2002).

Obesity then, is a symptom of this disordered eating behavior, which is more typical of African Americans (Collins & Winkleby, 2003; Gore, 1999; Root, 1990; Thompson, 1992).

Researchers have found that proportionately, more African American women are overweight and obese in comparison to White women (Collins & Winkleby, 2003; Gore, 1999; Kumanyika, 1994; Wifley, et al., 1996). Other women of color are noted as having high obesity rates, with Hispanic women running a close second to African American women (Adderly-Kelly & Williams-Stephens, 2003; Kumanyika, 1994). The incidence of obesity among other women of color suggests that they may share similar cultural experiences and racial and class oppression with African American women.

Eating behaviors that lead to obesity in African American women have not been linked to the western cultural ideals of beauty and thinness as they have with White women. One reason may be that the roots of African American women's eating problem can be traced to cultural patterns that emerged in the 17th century when many Africans were brought to America against their will. Roslyn Terborg-Penn (1994) has identified several historical factors that may have influenced contemporary African American women's eating habits. These factors include a legacy of double standards within an oppressive system of slavery, heavy work expectations, limited control of one's own body, and no control of maintaining one's family. Enslaved women were the food producers and rearers of their own children, the children of other enslaved people as well as the master's children. Family survival depended on establishing what is now referred to as fictive or "play" kin: people who take the role of family member without being related (Collins, 1991; Staples, 1994).

Contemporary food patterns have their origin in an institution of slavery where African American women had to prepare meals for themselves and their families from limited resources

(Bryant & Neff-Smith, 1992; Gore, 1999; Poe, 1999). Slave cooks created a cuisine high in fat, sugar, cereal based on cornmeal, and cured pork as daily staples (Gore, 1999; Semmes, 1996). African American women used foods indigenous to North America that resembled African plants, such as the sweet potato, peanuts, watermelon and okra. Some were allowed to raise their own pigs or chickens (Poe, 1999). Those less fortunate developed an affinity for the parts of animals normally discarded by Whites. The entrails, or chitterlings ("chitlins"), and feet of pigs and chicken became favorite food items in the diet of African Americans and southern Whites (Poe, 1999).

Sundays and holidays were times when slaves were allowed to eat large celebratory meals with extended kinship groups (Blassingame, 1972; Poe, 1999), a tradition that remains today. After emancipation, these food practices continued because of limited resources and cultural preference. Though these food mores are associated with the South, African Americans who migrated to the North carried the southern cooking and the ritual of Sunday dinner with them (McAdoo, 1998; Poe, 1999). This preference for a high-fat diet is associated with a number of health problems affecting African Americans today.

Other historical components that have contributed to the epidemic of obesity among African American women are culturally transmitted coping strategies that entail the repression and displacement of emotion (hooks, 1993). These coping strategies are correlated with mental and physical illness (Northrup, 2001), and African Americans are at greater risk of developing physical and emotional illness. The African American woman is particularly at risk because of a pervasive socio-cultural stereotype that she is "strong" and can handle whatever life sends her way. This call to strength encourages the suppression of her pain which, for many African American women, is manifested in emotionally numbing ways like overeating.

Body Image: A Cultural Perspective

Body image is a complex multidimensional construct. According to Lovejoy (2001) there are two key components of this construct: attitudinal body image and perceptual body image. Attitudinal body image refers to a person's degree of satisfaction with her body, while perceptual body image concerns the accuracy or distortion in a person's self-perception of physical body size.

White women tend to be more dissatisfied with their weight even when it falls in the normal range, and African American women tend to have less dissatisfaction with their body size and self-image even when they are heavier than the medical standard (Wilfley, et al, 1996). Researchers who examine perceptual differences in body image have found that White women tend to hold ideals of body size that are thinner than the body-size ideals of African American women (Hesse-Biber, Howling, Leavy & Lovejoy, 2004; Lovejoy, 2001). African American women tend to think their weight is average when in fact they are overweight (Lovejoy, 2001). Both groups have distorted body images, but the distortions move in opposite extremes. Dortch (1999) found broad acceptance of being overweight among African American women. Similarly, Gore (1999) found that African American women had to become a great deal heavier than European American women before they defined themselves as overweight.

Perceptions of weight had cultural significance as well as individual and family significance. Family gatherings and heritage were powerful themes in the focus groups of Gore's study. One participant spoke of the food choices African American women make.

> It's a cultural thing. It's how we evolved as a race of people. And it's true those were probably the cheaper items, also, in that the masters probably had the best foods and the

slaves got what was left over. Those foods were higher in fat, and that's probably where our taste for those foods came from. That's what I think. (Gore, 1999 p. 76).

This group of women viewed weight as part of a cultural tradition passed down from generation to generation. This tradition included the foods they ate, and the social context of family gatherings where food was the central focus (Gore, 1999).

These studies and the history of African Americans suggest that being overweight is more socially accepted among African American women and is viewed as problematic only when health issues arise. According to Beauboeuf-Lafontant (2001), African American culture assumes that heavy weight in Black women is normal, and that Black women (and Black men) prefer *thick*-ness to the *thin* images of beauty associated with White females. Heavy weight is associated with inner strength and stamina and, therefore, large Black women are often viewed as strong and not in need of emotional/psychological support.

There are two pernicious cultural archetypes of the large Black woman, the *Mammy,* and the *Strong Black Woman.* The *Mammy* is a passive, nurturing, large Black woman who serves her master selflessly and gratefully, be it as slave or domestic housekeeper (hooks, 1981; Beauboeuf-Lafontant, 2001). Some scholars describe this image as an attempt to justify slavery and the oppression of Black women by normalizing the large, dark-skinned, passive and sexless caretaker (Beauboeuf-Lafontant, 2001; Collins, 1990; hooks, 1981). This archetype was popularized by the *Mammy* figure in "Gone with the Wind."

The *Strong Black Woman* is an archetype more closely identified with contemporary African American culture. Thompson (1992) described it as the woman who raises her children, works numerous jobs, and supports her extended family. bell hooks (1981, p 83) characterized this perception of strength as a "stoical acceptance of situations we have been powerless to

change." Beauboeuf-Lafontant (2001) argued that this stereotype, an inversion of the *Mammy* myth, serves to promote a denial of the self. This denial and emotional starvation promote overeating and an unhealthy connection to food. Eating becomes one of the few legitimate ways of nurturing the self.

The contemporary cultural stereotype of African American women is one who is sexually impulsive, immoral, and permissive or the *Jezebel* (Gay, 1999). Clinical psychologist Patricia Gay concluded that this stereotyping has led to sexual trauma that has been institutionalized. Her clinical experiences with African American women suggested that they "live with a bombardment of sexual stereotypes that have been institutionalized, and … continue to sexually abuse" (1999, p. 5). The aforementioned stereotypes of *Mammy* and *Strong Black Woman* carry connotations of asexual or masculine women as well. The *Jezebel* connotes a woman who is hypersexual. These messages can impact the roles African American women play in their relationships and families

Family and Community Roles

While the strength attributed to African American women is, to a point, a worthy and desirable trait, it can promote unhealthy roles that ignore the personal needs of the individual. When asked about behavior that promotes health and emotional well being, such as physical activity, African American women in one study (Banks-Wallace, 1999) agreed that their first responsibility was to their family and community. Banks-Wallace (1999) reported that African American middle-age women, whose responsibilities to family and community left little time for self-care, were aware of the benefits of physical activity, but most had been raised to put family needs before their own. Of the roles and responsibilities their mothers had to bear, they said:

> … it comes from our mothers. Because they tolerated and they put up with a lot [they sure did]. You know, and at the same time, you know, we know that they were strong. And I guess that somewhere along the line we are still strong to a point, but our mothers were some strong Black women [that's right]. We know they were. Because they put up with a lot more than we ever dreamed of today (Banks-Wallace, 1999, p. 28).

This call to strength is tied to loyalty to family and race. Central to being an African American woman is being a "good" mother, and motherhood in the Black community extends beyond the typical role of mother to one's biological or legally adopted children. The role of mother is a fluid one, not limited by biology and blood. Fictive kin or *other mothers* are women who assist the biological parent in raising children (Collins, 1991).

Beauboeuf-Lafontant (2001) contended that the discourse of the *Strong Black Woman* has currency "within and outside the Black community." It is a discourse that silences the voice of African American women who wish to speak of their pain, weakness or distress. These painful feelings can include the ongoing stress of racism. Feelings of anger, powerlessness and a hostile environment typify the experiences of discrimination related to racism (Kempa & Thomas, 2000).

Thompson (1992) suggested that eating disorders in African American women might be associated with internalized oppression. Internalized oppression occurs when the oppressed unconsciously identifies with the oppressor, and acts towards the self in an unfair or harsh manner. In other words, overeating becomes an expression of self-discrimination related to the experience of racism.

Additionally, Thompson (1992) found overeating in African America women to be related to experiences of sexual abuse. The sexual abuse of African American women has its

historical origins in slavery, where African women were raped on slave ships, displayed naked on auction blocks, groped and examined for their sturdiness and breeding ability, and sexually exploited by their slave masters (Gay, 1999; McAdoo, 1998). Historian John Blassingame (1972) described the powerless bind African American women, girls and their parents faced during slavery:

> The white man's lust for black women was one of the most serious impediments to the development of morality. The white man's pursuit of black women frequently destroyed any possibility that comely black girls could remain chaste for long. Few slave parents could protect their pretty daughters from the sexual advances of white men (p.82).

This experience gave the clear message that control of African American women's bodies and their sexuality belonged to others.

Mother-Daughter Relationships

Several researchers have found correlates between mother-daughter relationships and eating disturbances such as anorexia and bulimia (Benedikt, Wertheim, & Love, 1998; Hahn-Smith & Smith, 2001; Lattimore, Wagner & Gowers, 2000; Pike & Rodin, 1991). Similarly, theorists who have looked at changing gender roles suggest that conflict in the mother-daughter relationship is at the center of eating disorders (Orbach, 1986; Perlick and Silverstein, 1994). Perlick and Silverstein (1994) argued that girls who experienced greater social and economic opportunity, as well as expanded gender role possibilities, might have conflictual feelings about their role prospects and the role limitations their mothers had to accept. Since this research is most often based on middle-class White families, the data are not generalizable to African American families. What is generalizable across ethnic and economic backgrounds is the importance of mother-daughter relationships to daughters' self esteem and self-image.

Often, the earliest role model for self is found in the mother or key female relationships. The daughter learns about being a woman as she watches and listens to her mother. Mother-daughter relationships, in African American families, are rooted in African cultural perspectives on parenting roles. In the West African tradition mothering was not a job reserved for birth mothers, and financial responsibility for the family was not the sole responsibility of the father. Collins (1991, p. 45) wrote:

> Emotional care for children and providing for their physical survival were interwoven as interdependent, complementary dimensions of motherhood ... While the biological mother child bond is valued, child care was a collective responsibility, a situation fostering a cooperative, age-stratified, woman centered mothering network.

Alternately, Collins (1991) compares this view to the Eurocentric view that limits the roles of both White and African American women in the nuclear family characterized by White middle-class America. This family is divided in two spheres, male and female. The male sphere focused on economic provision for the family, and the female sphere focused on affective nurturing. The dominant patriarchal perspective encourages women to maintain roles of caretaker for the child, nurturer of the husband and maintenance of the home.

Collins (1991) asserted that while women are challenging this long-held perspective of the dominant culture, it has negatively influenced women across ethnic groups. What this means for African American mother-daughter relationships is that mothers have the task of teaching their daughters about the impact of sexism and racism specific to their identity, as well as helping them understand the ways the mandates for motherhood from the dominant culture may impact their lives. This task includes teaching their daughters how to survive in a society where they will face discrimination based on race and gender, and helping them find ways to cope and

become their best selves (Collins, 1993). The face of discrimination may be different than the one the mother dealt with, and consequently the daughter's strategies for coping will require the ability to apply knowledge about discrimination to new situations. Key to developing this ability is a positive self-esteem that allows the daughter to recognize when the self is threatened or devalued by racial or gender discrimination (Turnage, 2004). Mothers' role in developing this self-esteem is pivotal for the African American daughter (Bell-Scott, et al, 1993; Green, 1990; Collins, 1993; Thornton, Chatters, Taylor & Allen, 1990). Hopefully, in learning about their mothers' and grandmothers' experience of sexism and racism, daughters are then helped to recognize the ways their lives are influenced by it today.

The task, then, of the next generation is to live in ways the previous generation could not. The mother, in the hopes that the daughter will see new ways to feed her soul, passes down the historical legacy. This mother-daughter legacy includes the mixed message "to be strong" which, as discussed earlier, can negate or deny important feelings of powerlessness and pain. It also includes a message to find beauty in your self and ignore the dominant standards of beauty. While useful in many ways, this can support the use of food as a comfort drug, and being overweight as normative. This can lead young adult women into middle and later adulthood with a sense that the "thick" body image is acceptable, even preferable, and that overeating is justifiable as a way of coping. By middle and later adulthood, obesity becomes the norm.

Being overweight and an African American woman is not always indicative of disordered eating. Nonetheless, the disproportionate number of overweight and obese African American women point to a need for an assessment of eating disturbances that include emotional and mental health components.

CHAPTER III

THEORY

In this section, I discuss theoretical perspectives that were used for understanding the phenomena. Uri Bronfenbrenner's (1979) ecological systems theory provided a framework for conceptualizing individual issues within multiple contexts. This theory allowed for the exploration of historical, cultural and social issues, as well as family experiences of African American women. Black feminist theory, which centers the issues of gender, class and race, was especially relevant to this exploration of disordered eating in African American women. The last perspective I used was Engle's biopsychosocial model that addresses obesity as both a medical issue and a social behavioral concern.

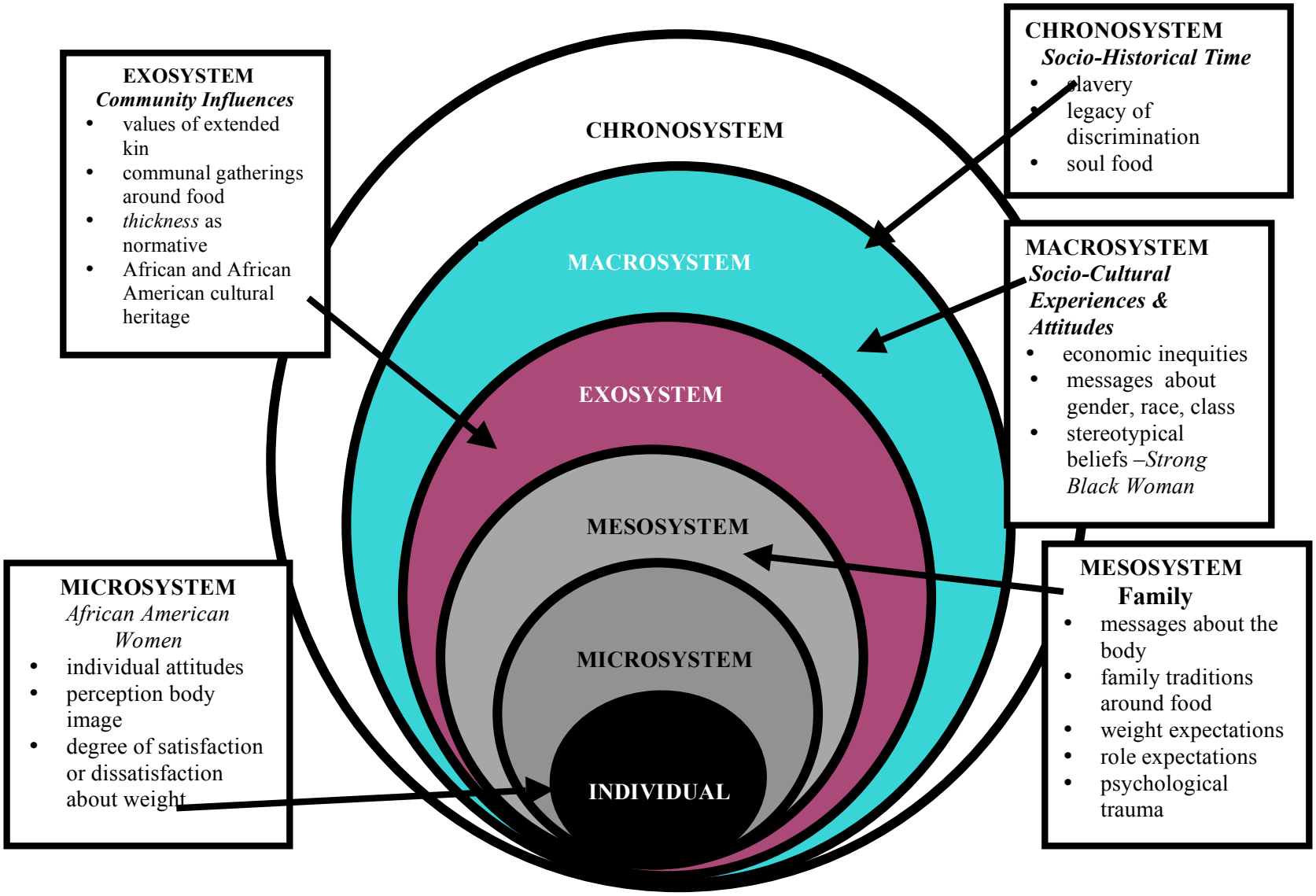
The first theoretical perspective I used for exploring issues of overweight in African American women was Bronfenbrenner's ecological model (Bronfenbrenner, 1979). The ecological model recognizes the interdependence of intra- and extra-familial processes and considers social, cultural and historical factors. Conceptually, this framework is characterized by five nested structures: the microsystem (the individual), the mesosystem (the family), the exosystem (the community), the macrosystem (larger society-social and cultural influences), and the chronosystem (historical time).

The microsystem comprises an individual's attitudes, perceptions and degrees of satisfaction or dissatisfaction about herself and her weight. Individuals may perceive themselves as average weight when they are overweight by medical standards. The mesosystem includes family influences such as messages African American girls internalize about their bodies, their

sense of agency, and family traditions around food. These messages, for example, could include the idea that you are destined to be big or "thick" or the message that family dinner must include fried foods and sweets to be satisfying and/or acceptable.

The exosystem includes community influences such as the values of extended kin, and fictive kin such as other mothers or play-siblings, and communal gatherings around food. At communal gatherings, covert and overt messages are given about the kinds and amount of food that are culturally desirable. Students in one of my undergraduate classes, which was composed of all African Americans, were told they could bring refreshments to celebrate the successful completion of a major project. I walked into class to find some students cooking sausage patties and links on an indoor grill. One student brought a crock pot of cheese grits. Their notion of celebration meant that large amounts of food would be present and the food would be culturally familiar. This was a morning class, so the food reflected a traditional southern breakfast meal including pork sausages and grits. Similarly African-American church services are often followed by dinner; a central ingredient to after-church activities. This could also reflect aspects of the macrosystem which includes socio-cultural messages about gender, race and class. Women in the church continue to be depicted as cheerful, selfless servants and men continue to dominate the leadership roles. The chronosystem includes the social-historical legacy of discrimination, including enslavement of African Americans. Together, the five interrelated systems of Bronfenbrenner's model offer clues to how the African American woman develops problems around eating that lead to obesity. (See Figure 1)

Figure 1: Conceptual Model of Ecological Theory Applied to Disordered Eating and Obesity in African American Women


CHRONOSYSTEM
MACROSYSTEM
EXOSYSTEM
MESOSYSTEM
MICROSYSTEM
INDIVIDUAL
CHRONOSYSTEM
Socio-Historical Time
• slavery
• legacy of discrimination
• soul food
EXOSYSTEM
Community Influences
• values of extended kin
• communal gatherings around food
• thickness as normative
• African and African American cultural heritage
MACROSYSTEM
Socio-Cultural Experiences & Attitudes
• economic inequities
• messages about gender, race, class
• stereotypical beliefs –Strong Black Woman
MESOSYSTEM
Family
• messages about the body
• family traditions around food
• weight expectations
• role expectations
• psychological trauma
MICROSYSTEM
African American Women
• individual attitudes
• perception body image
• degree of satisfaction or dissatisfaction about weight

While this framework is a very useful guide, my review of the literature on obesity and overeating in African American women suggested that an exploration of the issues of weight for African American women require a Black feminist lens. This perspective can also be viewed as aspects of the ecological model, related to the historical, social and cultural factors influencing the individual. (See Figure 1).

Black feminist thought provides a political, sociological, and psychological framework for looking at the combination of gender, class and race. bell hooks (1984, p. 2) defines feminism as "the struggle to end sexual oppression." Feminist theorists focus on the ways women and men have been oppressed because of their gender, class, and sexual orientation. Orbach (1988) asserted that fat is a feminist issue because of the oppression eating disordered women suffer in a society that has violated and ignored them. This is not unique to the struggles with food and weight African American women experience. What is distinctive is the combination of race and gender issues that have resulted in their oppression.

Beauboeuf-Lafontant (2001) argued that the issues of oppression are similar whether the woman is starving or overeating. The difference lay in the cultural experience that influenced the women. African American women have been depicted as a group that is not influenced by the dominant societal standards of beauty, which is that of a thin woman. Furthermore, the image of the *Strong Black Woman* lessens the likelihood that symptoms of pain will be recognized in this population (Beauboeuf-Lafontant, 2001; Thompson, 1992; Root, 1990). For this reason, Black feminist theorists offer a lens that allows for the consideration of both sexual and racial oppression.

Black feminist thought encompasses theoretical interpretations of the lived reality of African American women (Collins, 1991). A Black women's standpoint is central to Black

feminist thought which is defined by Collins (1991, p. 32) as "the African American woman's vision of self, community and society." Core themes of Black feminist thought relevant to the issue of obesity in African American women are:

1) The legacy of struggle against discrimination,
2) Recognition of the intersection of race, gender, class and sexual orientation, and
3) The impact of negative images of Black womanhood and the need for positive, self-defined image.

African American women are historically bound by a legacy of struggle that began with slavery and continues through the oppressive experiences of discrimination around race, gender, class, and sexual orientation. While obesity is a life threatening symptom/disorder that affects more than half of African American women of various ages, socio-economic statuses, classes and sexual orientations (Gore, 1999), it is not addressed holistically as are other symptoms of disordered eating that primarily impact the lives of White women. In fact, the *Diagnostic and Statistical Manual of the American Psychiatric Association* (1994) lists diagnostic criteria for anorexia, bulimia, and binge eating disorder, and eating disorders not otherwise specified. Whereas, overeating, which is more common among African American women, is not addressed in detail. Thus, African American women are less likely to be recognized as needing mental and emotional support for their disordered eating because it does not easily fit established guidelines (Tyler, 2003).

Gore, 1999; Stevens, Kumanyika, & Keil, 1994; Tyler, 2003 have suggested that African American women self-define larger body size as positive. Several scholars argue that the genealogy of this positive representation derives from self images that, consciously and unconsciously, hurt African American women; images such as *The Mammy*, *The Strong Black*

Woman, and *The Superwoman* (Beauboeuf-Lafontant, 2003; Collins, 1991; hooks, 1994; Thompson, 1992).

Black feminist ideology encourages research that centers the experiences of African American women, to give voice to those rarely heard (Few, Stephens & Rouse, 2003; Collins, 1991; Hull, Bell-Scott & Smith, 1994). "To be means to communicate. Absolute death (nonbeing) is the state of being unheard, unrecognized, unremembered ..." (Bakhtin, 1984, p. 287) Research on disordered eating in African American women requires us to look at the ways the lived experiences of African American women are linked to their weight. With a Black feminist lens, overeating and obesity are less likely to be dismissed as the result of normative cultural experiences and more likely to be heard as symptoms/themes of oppressed women.

The last model that I used to inform my study provided a tool for addressing obesity as both a medical concern and a psychological/social problem. This model, the biopsychosocial model was introduced by George Engle in 1977 as a paradigm shift from the biomedical model that separated disease from social behavior and experience. It establishes a relationship between the clinical data of illness to the behavioral and psychosocial data related to the disease (Engle, 1992a; Engle, 1992b). This model speaks to the aspect of obesity in African American women that is viewed by the medical community as a "problem of living" (Engle 1992a, p.325); it is the patient's responsibility until a disorder or disease develops. When weight reaches an extreme or severe level, then it is viewed as a symptom of a medical problem, and a risk factor for other medical problems. It is often addressed with education about the body's response to weight gain and loss. Engle (1992a) maintained that the separation of medical disorders and behavioral experiences (problems of living) are harmful to the healing process. He likened the biopsychosocial model to systems theory where the whole (person, family, society) is recognized

as being a part of an isomorphic process where a hierarchical relationship exists and change in one part of a system affects change in the other. He suggested that emotions, life experiences and stressful events may be components of a disease symptom.

For the overweight and obese African American woman, issues of family, community, culture, history, race and gender discrimination must be addressed as a part of a whole approach to healing. The three theories I have chosen are similar in that they present the idea that the individual is a part of a system that impacts that life experience. This study focuses on obesity as a symptom that is medical, emotional, and social in nature.

CHAPTER IV

METHODOLOGY

In this chapter I outline the reasons why a qualitative approach was selected, discuss the usefulness of the chosen theoretical framework, present the characteristics of the design, and address issues of trustworthiness. Data collection and analysis methods are described in detail.

Research on disordered eating in African American women requires us to look at the ways lived experiences connect to their weight. Theoretically and methodologically, researchers need to include perspectives that incorporate the historical legacy and modern-day oppression African American women face. Qualitative methods of in-depth interviewing and narrative analysis are useful in exploring African American women's lives from the vantage point that privileges perspective (Few, Stephens, & Arnett-Rouse, 2003).

The specific goals of this study were: 1) to describe African American women's experience of being overweight 2) to examine the relationship between stress and overeating in African American women and 3) to explore the life experiences that impact the outcome of obesity.

Qualitative Methodology

This study was based on a naturalistic paradigm. The naturalistic paradigm, according to Lincoln and Guba (1985), is based on the following axioms:

1. Realities are multiple, constructed and holistic.
2. The knower and the known are inseparable; therefore the participant and researcher influence one another.

3. Generalization is only possible through the formulation of working hypotheses that are context and time specific.
4. It is impossible to distinguish cause from effects as all entities are in a state of mutual simultaneous shaping.
5. Unlike traditional inquiry that is value free, the naturalist paradigm purports that inquiry is value-bound by the choice of the problem, theory, and context.

The supposition that multiple realities exist within and among individuals allows a virtual space for informants to share their lived experiences. This study sought to understand how emotional experiences are tied to choices women make in eating and activity levels that lead to obesity. These experiences may be tied to beliefs, strong emotional connections, denial or a host of other realities. Adequate information about participant beliefs and experiences can make seemingly incongruent behavior more understandable.

Like many research projects, this study was born from my personal and professional experiences. I am an African American woman who is overweight. I have spent a significant portion of my life dealing with an unhealthy relationship with food and weight issues. My professional work has been as a marriage and family therapist, and clinical social worker. For therapists, practice and research are often recursive; one informs the other (Gale et al, 1996)). As a professional, I had an opportunity to serve as a consultant for a grant focused on southern rural African American women leaders. One of my tasks was to help them look at family of origin messages that influence them. During my work with these women, approximately 300 of them, I was struck by the number of them that were overweight. I would estimate that 75% or more were overweight. My interest was piqued, and this study was born.

Design

Patton (1990) wrote about the paradox in the term *design* when doing qualitative research. The word *design* implies the use of a blueprint when in fact the naturalistic approach requires a more flexible approach to exploring phenomena. Qualitative designs emerge during the study, including the data collection phase (Lincoln & Guba, 1985; Patton, 1990). With this in mind, a general description of the research design used for this study will follow.

This study was guided by three research questions:

1. How do African American women describe the experience of being overweight?
2. What is the relationship between emotional stress and overeating in African American women?
3. What life experiences impact the outcome of obesity in African American women?

Preliminary screening was done to assure participants met the study criteria. Women in this study self-identified as African American, were between the ages of 40 and 60, had a body mass index (BMI) of 30 or more, and had been overweight for at least 10 years. An interview guide was developed with open-ended questions that invited the participants to convey their life experiences with food and weight. This interview guide provided a common set of questions for all participants, and left room to explore new areas that might emerge.

Trustworthiness

All ethical research undertakings require the researcher to focus on obtaining valid and reliable information. *Trustworthiness* is the term most often used to describe validity and reliability in qualitative methods (Krefting, 1991; Merriam, 1998). Whatever the paradigm, in

the end, ethically sound research findings are accountable or trustworthy. Lincoln & Guba (1985) suggested that the researcher's task is to persuade himself and his audience that the findings of his study are worthy of attention. In a positivistic paradigm this is done by internal validity, reliability, and the use of quality measurements or instruments. In a naturalistic paradigm, the qualitative researcher uses credibility, transferability, dependability, and the researcher as instrument to assure trustworthiness of the study.

Credibility

Credibility is analogous to internal validity in quantitative design. Its purpose is to assure that the study accurately reflects the multiple realities of the participants. According to Patton (1990), a credible qualitative study will address the techniques that were used to assure accuracy, any assumptions that under gird the study, and what the researcher brings to the study in terms of experience and perspective. The techniques I used to assure accuracy in this study were member checks, prolonged engagement and reflexive analysis.

Krefting (1991) describes member checks as the practice of reviewing relevant research materials with the participants. Member checks were conducted by taking the data back to the participants to assure accuracy. Prolonged engagement involved lengthy interviews and multiple interviews, when needed, to assure participant rapport and confidence. Reflexive analysis was done by keeping a journal throughout the research process. The journal included notes about design and procedure, as well as my reactions, thoughts and biases during the interview process.

As aforementioned, I brought personal and professional experience to the study. As a family therapist who has experience working with women whose disordered eating is tied to emotional experiences within their family of origin, I am keenly aware of the role family plays in self image and health habits. My experience as a family therapist was a positive parallel to my

role as researcher. In both roles, I had to ask the interviewee more questions as new information presented itself. I had to ask these questions without inserting my biases into the process. I also had to allow research participants or therapy clients to use the interviews to discover information or make meaning of their life experiences. While the process is different in each experience, their parallel nature added credibility to this study because it is focused on emotional linkages, and potentially therapeutic issues to specific phenomena -- obesity and overeating.

Transferability

Transferability is the degree to which a study can be applied to other contexts by different researchers (Lincoln & Guba, 1985; Krefting, 1991). It is similar to external validity or generalizability, but in qualitative research there is no assumption of generalizability (Lincoln & Guba, 1985). The focus is on the reader's ability to transfer aspects of the study across similar contexts and phenomena. My task as a qualitative research is to strengthen transferability. This study does this by providing rich and detailed information about the participants and contextual factors that may be relevant to future research efforts.

Dependability

Dependability in qualitative research is concerned with consistency (Lincoln & Guba, 1985). It questions the extent to which the process can be repeated. It is analogous to reliability, but the again the goal of qualitative research is to present the multiple realities or truths of its participants. A duplication of the qualitative research study will not yield the same results, but similarities may exist. The researcher provides details of the methods used to insure thoroughness.

Strategies that were used to insure dependability include detailed descriptions of the research methods, and dependability audits. Dependability audits are done by having others

review aspects of the research including methods, interview transcripts, and findings. My major professor, whose specialty is narrative analysis and interviewing, served as the primary auditor of the study.

Procedures

Sampling

Qualitative research often focuses in-depth on a given phenomena using purposeful samples. According to Patton (1990):

> "The purpose of purposeful sampling is to select information rich cases whose study will illuminate the questions under study." (p. 169)

I requested approval from the Institutional Review Board (IRB) for both a pilot and dissertation study in 2003. The study has been approved for five years (see Appendix A). I used purposeful sampling to recruit a homogenous group of women who have experienced weight gain and obesity over a significant portion of their lives. Because I selected participants based on very specific criteria, a random sample was contraindicated.

The goal of this research effort was to reach a point of saturation. Lincoln and Guba (1991) recommend adding participants until a point of saturation is reached. Saturation is reached when information is redundant and no new data are found. Similarly, participants were added in this study until information was repetitive.

It is important in sampling for a qualitative study that participants are homogenous. The criteria for this sample were:

1. that participants be African American women between the ages of 40 and 60
2. that participants have with a body mass index of 30 or above, and
3. that participants have been overweight for at least ten years

The age period was selected because it correlates with middle age, a time when women often take time to reflect on life experiences and begin to make meaning of choices and habitual behaviors (Northup, 2001). Because this study is focused on life experiences, it was important that the participants had a significant period of time that they have dealt with the issues of obesity and overeating.

Recruitment

Professional colleagues were made aware of the purpose of the study and asked to refer individuals for participation. Women referred for the study were asked to suggest others who would likely meet the criteria of the study. Six women were recruited for this study. Five other women volunteered, but four of them did not meet the age requirement. The fifth person was referred by a participant, but decided she did not want to give specific information about her weight.

Initially, contact was made with each potential participant to discuss the research criteria, determine BMI, and review consent forms. The consent form delineates the purpose of the study, procedures, and risks (see Appendix B). Participants were informed of their rights to withdraw from the study at any point, and they were assured of confidentiality. To those who were interested in this issue, but did not meet criteria for my study, I gave them a copy of a contemporary article (Appendix E) on obesity in African American women.

Data Collection

Data collection in qualitative research is most effective when the researcher and participant have established rapport. With this in mind, the interviews were scheduled and held at a time and location comfortable to the participants. Four of the participants preferred to meet

in a neutral location, and we met each time in my office or their office. Some preferred a more personal setting; I met one participant at her home, and another at her friend's home.

The interviews were directed by an interview guide (see Appendix D). This semi-structured outline guided the topics to be raised, and allowed flexibility for participants to share their stories or narratives (Reissman, 1993).

Participants were asked if they would like to use pseudonyms during the data collection and in the written presentation of the findings. One participant decided she wanted to use her first name, and another requested I use her middle name. As researcher-participant I used my first name. The remaining four used pseudonyms that they selected. They were told that interviews would be audio-taped and transcribed, and that the audio-tapes will be destroyed after one year. Participants were informed that the initial interview would last one to two hours and that additional interviews might be necessary for clarification or additional information. They were also contacted for member checks.

The Researcher's Journal

I kept a journal of reactions and thoughts after each interview. I used it initially to bracket my experience of the phenomena. It included my observations and participant interactions, important issues, follow up questions, and beginning categories for analysis. It was also used to help me gain some insight into those interview techniques and questions that elicited more open responses. An emic perspective or insider status is the desired goal in a qualitative research study that focuses on issues of a personal nature (Patton, 1990). Insider status is not always easily attained, and despite the parallels between my experience and participant experiences, it cannot be assumed. The researcher journal was used to note ways the interview process moved toward a more emic perspective.

Data Analysis

Narrative analysis was chosen as a useful method for examining the emotional experiences of overweight African American women. Narrative analysis is the process through which the researcher organizes the data into a cogent account (Polkinghorne, 1995). This process includes data coding, analysis methods and data representation. This section outlines a model that is useful to data representation of narrative analysis. It describes the methods that were used to create the narrative.

Analysis and Data Representation

It is important that the qualitative researcher accurately represent the participants' experience of the phenomena. It is also important that that representation expresses the way participants have imposed meaning and order to their experiences. Reissman (1993) provided a model of representation that is useful to this study. This model addresses multiple levels of representation including attending, telling, transcribing, analyzing and reading the experience.

Attending to the experience involves helping the participant to remember and reflect the experience. I developed the interview guide (Appendix D) with this task in mind. I asked open-ended questions that directed, but did not lead, the participant. For example, the first question in my interview guide was "Would you walk me through your experience of gaining weight?" By the beginning of the interview we had already established that the study was about weight gain. Many of the participants spent considerable time answering the first question. This question allowed them to place order on the experience and report events, issues, and developments that were meaningful to them; these are key elements of the first level of representation.

The second level focused on how the participant told their story. What is important at this level is the memory or aspects of the experience that the participant tells. Reissman (1993)

pointed out that there is a difference between the way the participant speaks of the experience and what actually took place. Meaning about the experience is then derived from the way the story is told. This study focuses on the emotional linkages to weight gain. The participants talked about and showed their emotions as they spoke of the experience.

Transcribing the data is the third level of data representation. The transcription allowed the researcher to have a written text of the interview. The transcripts in this study included verbal and nonverbal expression (e.g. laughter, sighs, and pauses). This assured that the data represented the sequence of interactions that were shared, and the importance of issues or experiences could be analyzed more holistically.

The next level involved the researcher's analysis of the data or transcripts. My task was to present the findings through reviewing, organizing and interpreting the experiences presented by the participants. I used open coding methods (Charmaz, 2002; Coffey & Atkinson, 1996; Strauss & Corbin, 1990) to begin the process of organizing the data. I reviewed each line of the transcript to look for leads and phrases that explained the participants' experiences of overeating and obesity. This line-by-line coding process (Charmaz, 2002) was a useful beginning place for building codes and themes.

In this study, a narrative was created that was a representation of the participant's story. The final presentation, then, is a combination of the transcription (the participant's story) and the researcher's interpretation of that story.

Finally, my task was to write the narrative for others to read. The reader becomes a part of the text as he/she interprets the written text. Reissman (1993) maintained that there is no master narrative, and multiple narratives develop with this interaction. My goal was that the final narratives reflect the interaction of researcher and participants.

CHAPTER V

PARTICIPANT NARRATIVES

In this section, I present vignettes of the participants. I share stories of each woman's experience with weight gain and overeating. I also use the vignettes to describe the participant, the interview setting, and the interactions we had during the interview. I used the conceptual model (see Figure 1) to organize my data, focusing on the participants' beliefs and attitudes, focusing on the participants' beliefs and attitudes towards gaining weight, family experiences, community, socio-cultural and historical experiences that have influenced their stories of overeating and gaining weight. Like the ecological model, the individual experience is nested in multiple layers that are separate and simultaneous. The participants' life stories tie the present to the past and the individual to family, community and the larger society.

The vignettes were constructed from the interview transcripts, my journal responses to each interview, and member checks. I provide the height, weight and body mass index (BMI) for each participant. The BMI was calculated from information they provided me about their height and weight. This study begins with my own story and for that reason I begin by writing about myself as researcher-participant. The other participant stories follow.

Terri

I am a 49-year-old woman who lives in middle Georgia. I was born in Atlanta and lived there until my teen years. We moved to a college town where I stayed until I moved to middle Georgia for a job. I am a college professor in the area of behavioral sciences and I also serve as department chair. I worked in the counseling field as a clinical social worker and family

therapist for about 15 years before teaching. I am married and I have two children, a son and a foster daughter, my niece, who has lived with us the majority of her life.

I am tall, brown skinned woman with large expressive eyes. I wear my short kinky hair in various styles, but most often I wear a braided style. I have a high pitched voice that I am told has a calming quality to it. I naturally speak slowly and deliberately, but I often match the style of my speech to the person with whom I am speaking. I am heaviest in the lower half of my body, with large hips and thighs. I am 5'8", 324 pounds and my BMI is 49; this places me in the extreme obese range of clinical obesity. I have struggled with disordered eating for all of my adult life.

Family Experiences

I grew up in my grandmother's house, where my mother and I lived until I was 13 and in the ninth grade. I was conceived when my mother was sexually assaulted at 19. While my mother was present in the home most of my childhood, my grandmother was my emotional mother. My grandmother was diabetic, and kept chocolate candy kisses in the refrigerator in case she had a drop in her blood sugar. One of my earliest memories is of my grandmother admonishing my cousins and me for eating her candy.

I believe I am addicted to sugar, and I believe this preceded my weight gain. My family tells a story of me drinking sugar water as a preschooler. I would fill a glass with water and struggle to reach the sugar bowl to put a spoon of sugar in it. My aunt asked me what I was doing, and I said, "Putting sugar in my water … I like it'. Another experience I had around sugar involved drinking coffee in the morning. My grandmother called it "coffee milk." We took the leftover coffee from my mother or uncle and added milk and sugar to it. It was a treat I had with my grandmother. I was probably around 5 or 6.

I recall feeling tremendous guilt in kindergarten when I spent my snack money, a dime, on 10 butter cookies. My mom told me to get five cookies and milk. I eliminated the milk for cookies. At my home, I could eat anything I wanted. I don't remember restrictions around food, or having particularly unhealthy foods around. However, white bread was the norm, and canned vegetables and fruits were staples in our home. In the summers, one of my aunts would visit and insist that the children eat their vegetables. I did not like mixed vegetables or turnip greens. My aunt would insist and threaten to take away dessert. I said I was fine with that. She thought I was being difficult. Sometimes my grandmother ate my vegetables when my aunt was not looking to keep the peace.

The first time I was aware of using sweets to deal with bad feelings was in junior high school. A boy I liked had rejected me. I went home and made brownies. I felt better after I ate them. I was now living with my mother and stepfather, and while we had most dinners together, I was at an age that food choices and snacks were left to my discretion. I began to use food for comfort.

When I was 15, we moved into a new house and my mother had a garden. She was very focused on healthy eating and vitamins. I was more weight conscious at that time, but I think it was the result of peers and racial integration. When we lived in Atlanta, the schools I attended were predominantly African American. Girls with big hips and legs were selected to be majorettes and beauty queens. In the integrated high school I now attended, skinny White girls with long hair were my peers, and they were considered attractive. I identified with the girls of color, but I believe the nonverbal messages about standards for beauty and looks affected us all.

Weight Gain and Overeating Experiences

The first weight gain I remember was around 12 years old. I went through a growth spurt, and I was 5'7" and I weighed 140 pounds. I was not overweight for my height. However, I had been a pretty skinny child, so I thought I was overweight because I was the largest I had ever been. I was bigger than my mother. My nickname was "Beanie*"* because I was tall and skinny like a string bean. By early adolescence my weight dropped. I had not dieted, but I had increased my physical activity. I was in the marching band and numerous extra curricular activities. My self image had already been distorted, so from adolescence onward, I worried about my weight. I saw myself as overweight even when I as a normal size.

I stayed within a healthy weight range until I was 19 or 20. Two stressful events impacted my weight. My mother died when I was a sophomore in college. When she died, I was 5'8" and weighed 150 pounds. With in a month of her death, I weighed 165 pounds. I was fasting, for religious reasons, before she died. Friends and family told me that this was not a good time to fast. I remember thinking, "I'm afraid to start eating because I might not stop." I don't think I ever stopped. I think the pain of loss was exacerbated by living at home with my alcoholic, bipolar stepfather and feeling the need to protect my younger sister from him. I traveled as often as I could during that period and moved out of the house after about four months.

The other event happened about a year after my mother's death. I had lived in my own apartment for about a year. I was sexually assaulted by a young man whom I had dated occasionally since high school. I did not realize until some time later that the appropriate term for that what happened was 'date rape.' We had never been sexually involved, and I had made it

clear that I was not interested in sex. Like so many women, I blamed myself and did not acknowledge that assault as rape until years later.

I read in a book called *Fat is a Feminist Issue* (Orbach, 1998) that one reason women gain weight is as a type of protection, especially when they have lost their mother. The weight serves as a type of armor or shield from sexual advances. I did not consciously decide to gain weight after my mother died or the rape incident, but the idea to use weight as armor rang true to me.

I gained about five to 10 pounds every year thereafter. I lost some weight my junior year of college to fit into a bathing suit for a fraternity queen competition. I lost weight, my senior year of college, to fit into my flag twirler uniform. I lost weight my second year out of graduate school. I had some health problems during that time. My weight had increased to 200 pounds, and I consulted with a doctor who suggested I give up sugar and red meat. I lost about 25 pounds, but gained it back the next year. My weight slowly crept up to 230 and I again lost about 25 pounds. I was in my late twenties and I had a roommate who exercised with me and cooked healthy meals. She moved out and I gained some of that weight back.

After graduate school in 1980, and for the next decade my weight increased. It seemed that after a short period of losing weight, I gained back the loss weight and more. It was a time in my life of tremendous emotional stress. I finished graduate school with a master's degree, obtained custody of my 8-year-old sister and moved to middle Georgia. I was essentially a single parent. Her father, my stepfather, gave me very little monetary support. He was also a constant source of conflict and pressure. To put it mildly, he was mentally ill. He drank heavily, was socially inappropriate, and grandiose in his thinking. I avoided him as much as possible, but since I was raising his child, I had to interact with him to some degree. I noticed that whenever

he was around or I had to interact with him, I overate. Once, he was put in jail for a period of time and wrote my sister letters telling her that he had met Wayne Williams, the man convicted of serial child killings in Atlanta. He sent her Williams' autograph. Talking to him about why this was inappropriate was like talking with one of my dysfunctional mental health clients. My sister would become ill and nervous when he came to visit. When she reached adolescence, she started acting out and running away. She had mood swings. She was diagnosed as bipolar as an adult, but I knew she was bipolar as a teen. During this period in my life I self medicated with food. It became my reward for surviving the stress of it all. I sought professional help to deal with my family issues and address weight and food. I was too much into survival mode to make us of the insights around weight issues that I gained in therapy. Maybe I just needed the food and weight more than the weight loss.

In 1989 my sister became a teen mother. I provided some support, but moved them out of my home at the end of that year. My weight stabilized for about a year. I did not lose much, but I did not gain.

The next year, I met my husband, and we married a year later. Early in the marriage I gained about 15 pounds. I gained that weight after a miscarriage. I was feeling sad about the loss and I did not pay much attention to my body at that point. I got pregnant about six months after the miscarriage. At the beginning of the pregnancy I weighed 240. I only gained 10 pounds during the pregnancy, five of which were in the last month of the pregnancy. While this is a period many women complain of weight gain, my experience was the opposite. The food I disliked the most during this period was sugar. After having my son, my cravings returned.

The next weight gain experience started when my son was five months old. I had just started teaching full time and became fatigued, short of breath, swollen and achy. I was

diagnosed with systemic lupus erythematosus (SLE) or lupus for short. I was put on steroids, the worst medicine for a woman struggling with her weight, for a period of two years. I gained 70 pounds on this medication. *Strong Black Woman* that I thought I was, I met the challenge with working harder, carrying more than my fair share at home, and continuing to provide support to my extended family. I took the role of grandmother to my sister's children and eventually started to raise the niece I have now. I would jokingly say my first book is going to be *I Was a Grandmother Before I Was a Mom.*

Having lupus caused joint pain and fatigue. I was not an active person, but my bouts of weight loss and weight maintenance were sustained through aerobics and dancing, my only favorite physical activity. I went through a period of depression. The level of responsibility I had at home, in my job, and in community groups was challenged by this chronic illness. Food became my reward for meeting the challenge. I asked my husband to bring me a "sweet treat" every day. I denied the problem by keeping healthy foods in my home, and seldom having desserts in the house. A bag of sugar could live in our cabinet for months. There was seldom overeating in the house. We, however, ate out frequently, and I met emotional discomfort with sweet snacks. My overeating decreased some over the years, but so did my physical activity.

In my 40s, I have been extremely overweight. People comment more about my need to lose weight than before, primarily out of concern for my health. I am amazed at the audacity of people, who do not know me, to give me advice about weight loss. My family and I laughed after riding in a New York taxi, and the driver said to me, out of nowhere, that if I wanted to lose weight I should eat green and yellow vegetables. This man was from Bangladesh and he was giving me advice in a thick accent. We imitated him for a week after the trip every time we had

green and yellow vegetables. After that incident I kept asking myself, "Did I miss something, did I ask him for his advice?" I was not assertive enough to say I did not ask for advice.

I believe sometimes that being overweight is seen as a statement of failure and therefore I am everyone's project who cares to address me. I have a friend who calls me her 'drinking buddy'. She too is overweight, and we call each other when we want to get drunk on some food we should not eat. When people give us advice on weight loss, we smile and say "thank you." Either of us could write our own book.

Self Perception and Body Image

I have always had difficulties seeing my self realistically. I thought I was very unattractive from the time I was a little girl. I was born at a time and in a culture that, while moving towards Black pride, was still caught up in the belief that White was right. So the lighter skinned you were, the prettier you were. Even though the African American community professed a love of more full figured women with big hips and thighs, there was an unspoken appreciation for lighter skin and long straight hair. I was a long legged, skinny, brown skinned girl with a higher pitched, softer voice than any woman in my family. My mother, grandmother and my four aunts were short, lighter skinned, and were all small when I was young. They also had stronger, deeper voices than mine. Some of them struggled with weight later in life. I did not see myself as being like them physically. I did, however, identify with them as smart, strong women.

When I was eight years old, one of my aunts adopted a baby girl who had dark brown skin. I loved this baby and pretended she was my sister because I felt like she looked like me. I was a tall girl. People commented on how big I was. "She sure is a big girl." or "Where did y'all get this big girl?" This was the seed for my belief that I was "larger than the average bear,"

so to speak. I now realize they were speaking of my height and not my weight. When puberty hit, and I did in fact gain weight, the struggle to lose weight began.

I was never really overweight in adolescence, but I believed I was. A few summers ago, a friend from high school sent me a picture of us on the beach. I remember that day because there were three of us in bikinis. I was very self conscious but took the picture. When I saw the picture recently, I almost did not recognize myself. My memory and perception of myself were not congruent with the girl in the photo. As I look at old photos, I recall my thoughts and insecurities around weight. My thinking about how I looked was always incongruous with the reality.

I mentioned that I had lost weight for a fraternity queen pageant in college. I was at an acceptable weight by medical standards. In fact, I was less than the top weight of the range for my height, and I wore a size 10 bathing suit for the competition. I was already the queen for our campus fraternity, and was competing at the state level. I won first runner up at the state competition and one of the fraternity members commented that if I were smaller I would have won first place. The competition was based on talent, intellect, vision and the bathing suit competition. That comment, however, hurt and stuck with me for quite a while. It seemed clear now that all of the other areas were less important.

The only times I noticed feeling comfortable about my looks and being overweight were when I got married and became pregnant. On my wedding day, I wore the traditional white, which supposedly makes heavy women look bigger. I tried the dress on several times in the bridal store before purchasing it. I started trying it on in October and I did not buy it until January. It was the same dress, and I liked it, but I did not trust my belief that it was flattering. The store had a platform for customers to stand on. Without fail, unsolicited customer comments

were very flattering. Women would gasp and say how beautiful I looked in the dress. After about four visits, I bought the dress and enjoyed the day.

While still very overweight, I have not gained or loss a significant amount of weight in the past two years. I fluctuate with the same five to six pounds. However, with aging my weight has shifted, and I have lost muscle tone. I am most concerned with the increased weight in my stomach. Health issues remain prevalent, and while I have been dealing with lupus for well over a decade, I now have high blood pressure, am borderline diabetic, and have hypothyroidism. I made a decision last year when my health issues seemed to worsen to address them holistically. I found a wonderful doctor who combined traditional medicine with holistic healing/natural therapy and spirituality. I am beginning to feel better physically. I am aware that there is a correlation between stressful times and overeating. Interestingly enough, I am surprised to see in recent photographs that I am so overweight. The distorted self image has reversed. I now think I am smaller than I really am.

Jean

Jean is a 57-year-old African American woman who has spent most of her adult life in middle Georgia. She is originally from a small town in South Carolina. She has worked in academic settings all of her adult life, and currently is working as a college professor. Jean is divorced and the mother of two adult children ages 33, and 34, and she is a grandmother.

Jean wore her hair in a short curly cut. She is a light skinned woman with hazel eyes that seem to smile as she talks with you. She spoke clearly and distinctly in a manner that said she was well-educated; southern woman who is African American. Her speech was formal initially, but it became informal as she became more comfortable with the interview process.

Jean was 5'5", 247 pounds and her BMI was 46, which placed her in the extremely obese category of clinical obesity. While she was clearly overweight, she did not look fat. She would likely be described as heavy or "thick" in the African American community. Her weight settles mainly in her hips, thighs and legs. By most standards, she is a very attractive woman. She mentioned that as a younger woman, she was told numerous times by friends and family that she was very pretty. She did not give much credence to this because she realized that beauty fades and she wanted to be a woman known for her substance rather than her appearance. Interestingly, she admitted in subsequent interviews that friends and colleagues still comment that she is an attractive woman.

Our first interview took place in Jean's home. It is picture perfect, and she lives alone. Jean was dressed comfortably in sweats and a casual top. She welcomed me into her den and offered me something to drink. Jean's den is a small covey that jets out from her kitchen. It is surrounded by large windows and looks out onto her back yard and deck. I sat on a soft caramel leather couch and looked out into the kitchen. A tastefully framed picture of an old Black man reading the Bible decorated the far wall. I expressed my admiration of the artwork, and Jean shared that she sees it as a moving piece of art that speaks to her spirit.

A second interview took place in Jean's office. Her office was simply decorated with a glass covered book shelf on one wall and a desk facing the opposite wall. She sat behind a larger desk with a computer to her side and a small window behind her. Her desk was very organized, as was the rest of her office. Jean was dressed professionally. She was wearing light makeup and earrings. While she was more formally dressed, she was more relaxed in the second interview.

Jean had given my research topic much thought and was eager to share her ideas. The quality I noticed most in Jean's interviews was that she took responsibility for her struggles with eating and obesity. She struck me as a no-nonsense person who held high expectations of herself and others.

Family Experiences

Jean is the seventh child in a family of eight children. She was raised in a small southern town with her mother, father and siblings. Her father worked on the railroad and was out of the home during the week and at home on weekends. Her mother stayed home with the children. Jean's parents instilled a strong value of education in their children, all of whom did well in school. Most of her siblings attended college after high school.

Unfortunately, Jean's mother died when she turned 17. Jean was entering her senior year of high school and her youngest sister was a sophomore. This death resulted in her oldest brother returning home to care for them while their father continued to work out of town during the week. Jean recalled that this brother was valedictorian of his class with considerable promise. He married shortly after high school and he was completing military duty with plans to attend college when he returned home to care for Jean and her younger sister. He was 26 years old, in the early years of his own marriage and the father of two small children. Jean believes that the burden of the responsibilities was the impetus for her brother's heavy drinking.

The year following her mother's death, Jean left home for college. She married in undergraduate school. She completed undergraduate school and had two daughters in her late twenties. While they were toddlers, she accompanied her husband to a college in the Mid-West, where he completed his doctorate. She obtained a masters degree at the same time. It was clear to her that her role was primary caretaker of the children and home. She resented this, and used

education to expand her world. Jean's husband met her independence and outspokenness with controlling behaviors that included physical abuse. Ultimately, she divorced him in her 30s. They worked at the same college, which made life stressful for Jean. Nonetheless, she felt tied to her job and therefore a small town community. She was a single parent with little emotional or material support for her children. She spent many of those years feeling afraid.

> I think back to my own situation where I was always afraid … afraid that there would not be enough money, afraid that the car would break down, and what would I do? … afraid that something would happen, I mean just fearful of life and not having anybody to share that with. Not having someone to reassure me.

Weight Gain and Overeating Experiences

Jean's first experiences with gaining weight were related to the normal weight gain that comes with adolescent development. She met this experience with resistance, thinking that something abnormal was happening to her body.

> Well, when I was in high school, I use to sleep in a girdle. My mother made me stop doing that. She believed it was bad for my circulation.

Although Jean's weight gain was very gradual, she was obsessed with dieting. She met each small gain in pounds with excessive dieting or exercise.

> I think back through the years, I was obsessed with overeating, I mean dieting. I'm taking amphetamines. I didn't know that they were dangerous. I have obsessed with exercise. I would go from walking five to seven miles and then eating two hamburgers with French fries, you know.

She read books and magazine articles on weight loss and dieting.

> I've read everything under the sun. I'm a master of nutrition, of what I should do. I've even enjoyed over the years, reading that kind of material, you know it was sort of an interesting thing for me to learn.

While Jean spent a number of years dieting and exercising, she kept the weight gain at bay with extreme exercise and attacking any gain with a new diet program. She admitted that she had been on every diet available. At one point, she joined Weight Watchers and became a lifetime member after meeting her goal weight.

> As far as the diets go, you name it, I've been on it. I've been on the Atkins diet, Pritikin diet, the Mayo clinic diet, and combinations of all of the above, where I just decided I'm gonna cut out one thing or another. I've always known that a diet high in saturated fat was not a healthy thing to have.

Jean told me that she continues to try to lose weight through dieting, and she almost always fails. She may stick with a plan for a short period, but eventually she reverts to overeating.

> The most recent one [diet] was just the first of March, when my kids and I sort of made a pact that we were going to start eating healthier, getting exercise. For a couple of weeks there, two weeks – walking, eating reasonable, weighing once a week, writing my weight down. It started on a Wednesday; every Wednesday I was to write my weight down. First week [I was] four pounds down, the week after that, two pounds up, the week after that, no weighing at all. I would eat a reasonable breakfast, but as the day would go on, I would get hungry or just feel – sometimes I wasn't even hungry, I just felt on the edge of losing it. I found that when I would cook my meals at home, I ate very healthy, but I was

lonely here at home. So that's where I am with that, it just looks like a roller coaster of insanity.

Her children offered to join in her healthy eating and exercise to motivate her. Their efforts to encourage her left her feeling ashamed and disheartened. Jean saw herself as a failure and questioned, why?

They said 'Why don't you do it for Auntie? Why don't you do it for your grandchildren?' And then I was feeling ashamed, 'cause I'm thinking, why the hell can't I just do it for myself? I mean, why am I not worthy to just do it for me? [They were] trying to find something that would be important enough for me to really stay committed.

She did make one commitment. Jean said she grew up on heavy fats. She made sure that she raised her children differently.

So, having grown up on lard and butter, these two things sound alarms for me. Certain fat foods, like pork, pork foods and butter -- although I might do just as much damage on something else that doesn't sound an alarm. I certainly did not make that a part of my cooking habits, even as an adult, so my kids never experienced that, which was just a routine part of my childhood.

Jean was pleased that her children do not have the same issues as she has had with food. Her smile turned sour as she remembered her own struggles. She discussed food as if it was a person with whom she has a relationship, rather than as an object..

Food still continues to be a kind of comfort, you know. It's a kind of entertainment. It is a vehicle to make me feel connected. It's really weird , because whenever there is group feasting I have this desire to pull back … I don't want to participate in what seems to be

> group feasting … the self consciousness is always there … the feeling of guilt is always there.

Jean believed that most overeaters have foods that are nemesis foods, such as chocolate and fried foods, which they could not resist. Her nemesis foods changed over time.

> I wouldn't touch chocolate, but it's not because I have so much discipline, it's just not one of my nemeses. I think if it were, I'd be gorging chocolate, but frankly I'm not aware of any particular nemesis that I crave and have to have [now]. I use to like potatoes, sweet potato, pie, cookies. After my hysterectomy, I think there was a point in which I felt a little more balance. And now, I don't really crave a lot of food at all, but I'm not losing any weight either.

Self Perception and Body Image

As previously mentioned, Jean admitted having a distorted self image in early adolescence, when she wanted to sleep in a girdle. She shared pictures from her late teens and early twenties. She was never overweight and from the pictures, it appears she was on the thinner side of average body build. She was not underweight; she had a very attractive body, yet she remembered being displeased with her body during those years.

> I was really looking quite nice and I always wanted to be 20 pounds lighter. I wanted to almost be emaciated as opposed to just healthy. Any lumpy tissue, at all, was construed as fat. I was probably desirable but, you know, in my mind I wasn't. I've always thought I was fat, overweight. Now in retrospect, I realize that I was normal. I was normal in high school, I was a normal size in college, I was a normal size as a young adult, but I always wanted to weigh less. Now, I don't think I'm a normal size. I mean, I feel pretty sure that I'm bigger than I need to be, but I'm thinking back to the

times when I thought I was fat and now I look back and I wasn't big at all. Other people always told me that, but I never saw that.

Jean was aware that her views of herself were distorted, but she still sounded unsure about her body size. Given that her perception of her body was erroneous in the past, she believed she cannot see herself accurately today. She avoided going out, and she did not want to run into people who had not seen her in a while. This made family and class reunions difficult.

I remember not wanting to go to social outings, because I didn't want to see people who hadn't seen me for a while, especially when I would go home. I didn't want anybody to notice that I had gained weight. It just sort of reinforced this image that I had of myself, that I was just gross.

Jean did not report a lot of health issues because of her weight. She has noticed that she has less energy and some knee-joint pain that she attributes to carrying too much weight. Recently, she learned that her cholesterol levels were high. She has not, however, had a major or chronic disorder. She may have kept some health problems at bay because she had exercised and ate healthily for long periods. When she was in her thirties, she owned a gym and, despite unhealthy eating, she was exercising. Her doctor has admonished her to return to her healthier habits. While Jean does not consistently eat healthily, she does not totally ignore her health. She makes regular doctor visits and she has annual physicals. She knows her doctor will not be pleased with her weight.

Every year I get a tongue lashing about exercise and losing weight. And I come back every year with more weight gained.

This weight gain has also affected Jean's thinking about herself as a sexual being and consequently impacted the way she has related to men. She believed men no longer found her

attractive. She would like to have a meaningful relationship with a man, but she gave up on that idea when she could not lose the weight.

> It most certainly affected my sexuality, because, of all of the people that I thought would have an opinion about my body, it would be any man who might see me in the nude. And when I thought I looked good or felt good about myself, then I didn't mind. But, whenever I felt that I didn't look good then I didn't want anybody to see me in a kind of revealing way, whether it was clothes on that called attention to my body outline, or whether it was no clothes on at all. I mean I just expected that anybody that spent time with me that it had to do with conditional love that was based on how I looked.

Jean experienced rejection from men as she became more overweight. She admitted, however, that it was not always a clear rejection; she assumed this was the reason they pulled back. At times she bowed out of relationships to avoid the rejection.

> Sometimes they – men – would, I think, try to be more graceful about it. I think they are visual creatures for the most part, and anytime that visual is not erotic enough to keep them interested, then it affects their sexuality. I just assumed, men don't care about you anyway, they just want to use you, and they don't love you. When you've had a man that you've been sexually intimate with tell you that you need to lose weight, then that's a sign right there. The message to me is that if you don't [lose weight], I'm out of here.

Jean's beliefs about men and love were fueled early in life by her experiences with her father. While a hard worker, he was absent from home for much of the time, and emotionally absent even when at home. She longed for a man in her life that made it clear that she was really important to him. She idealized the relationship Condoleezza Rice had with her father. Jean

believed Rice's success and self-assurance are the result of a present father with whom she bonded.

> I remember reading something about how her dad always took her with him. He worked in the civil right movement in Birmingham. As a little girl, she followed him around and she was learning from him, but she was also bonding with him. He mentored her, showing her how to be – even unconsciously or without words or lectures, but showing her how to become a successful person, knowing without a doubt she was the apple of his heart. It just seems to me, if you grow up with that kind of love, then you're okay with yourself. I do know that it's what I would have wanted with my daddy, but I didn't have it. It is what I would have wanted with my husband, but I didn't have it. Then I had a very important man in my life, and I wasn't on the top of his list either. So somewhere in all of this I have learned that those people don't care about me. Accepting that they don't care at least stops me from seeking attention from that source.

Jean did not believe that Rice's experience was not the norm for African American women.

She has noticed that African American women are more overweight than White women. Jean attributed the differences to the privilege White women experience and the vestiges of racism that plague African Americans.

> I look around and I see that an awful lot of Black woman are obese. And they're not just middle-aged; even young girls appear not to be body conscious so much. I mean they don't even seem to have the vanity that would be natural for a 22-year-old. [They are] bigger and bigger and bigger, as if bigger is becoming the accepted norm, you know. But I think about the Black culture and that it is totally stress-ridden. That some ungodly

number of people living in single households and they live on less than that which is adequate to live comfortably. And their lives are seen – always in stress mode.

She recalled the pain of her own existence as a single parent trying to make ends meet and experiencing fear and distress over the enormity of her task. She believed that White women are taken care of even when they experience similar distress.

When I look at my White counterpart, she looks like a pampered creature. I mean, the image of that person that's the American definition of beauty and that person is – doesn't do dirty work and even a man who's not faithful to his family, not faithful to his wife, still regards her in a manner that makes her feel worthy to be taken care of. It just looks like White women are nurtured. Everybody's got their backs. It's like even a single White woman who needs a job; everybody is concerned about her getting a job. I'm sure that's not true, but that's what it feels like.

Jean has found that she is at a point in her life that her weight was not going up and down as it did in her earlier years. She has reached a place of acceptance. The acceptance was a sad realization about a cultural devaluation of African American women, a desire to move to weight loss for health rather than appearances, and letting go of her desire for a man that loves her unconditionally.

I think that moving in that direction had more to do with giving up on men folk, so to speak. That is just a futile waste of time, trying to make something happen there. Something meaningful, you know. So the giving up – the place of self- acceptance has just come with maturity, I think – and this being okay or at peace with not having a significant man in my life.

Sue

Sue is a 41-year-old woman who lives in a North Georgia college town. Sue has struggled with weight issues for many years, with her top weight probably reaching around 270. At the time of our interview, she was eating more healthily and exercising regularly. We met in her office, and she had a box of Go Lean Crunch cereal on her desk. I mentioned that that is a cereal I like. She told me that this was one of the healthy snacks she keeps near by. Sue showed me the inside drawer of her desk, where she keeps healthy snacks including fresh fruit, low-fat foods, and protein health bars. She seemed proud of her eating habits and laughed as she recalled what her favorite snacks were in the past.

Sue is an attractive dark brown woman with strong African facial features. Her lips are full and her nose is broad. She wore her hair in a short straightened cut, and her bright brown eyes are welcoming. She was 5'2", weighed 191 pounds and had a BMI of 35 placing her in the obese range of clinical obesity.

Sue has an infectious laugh that made talking with her very easy. She coordinates a research program, so she was very familiar with the interview process. We agreed to meet the first time for one hour, but the interview lasted over two hours. Sue said that she found talking about this issue cathartic; she enjoyed the opportunity to share.

Family Experiences

Sue's life story sounded like something from a talk show or a fairy tale. It actually began with her mother leaving her on a door step.

> But you know I think a lot of my issues – and actually I really am gonna probably write a book about this one day – stems from the fact that I was adopted. And, I think if I really look back, it's gotta be some abandonment issues going on there, because my mom gave

me up and she left me, abandoned me on a door step, literally, on a door step. So I think that's got a lot to do with how I feel about some things. I feel – maybe I push people away, I don't know, maybe – and I always felt it was because of self-esteem—

I'm sure it leads back to my eating and my self-esteem leads back to that.

Yet her adoptive parents were, according to Sue, "the most loving people." They were people who always supported her and made her feel good about her self. Sue said she does not resent her biological mother's decision. She believes she could not have been a better parent than her adoptive ones. She finds comfort in believing that her biological mother was probably a young single woman overwhelmed with the responsibility of a child.

Sue felt abandoned again when her adoptive parents died during her teens. Already middle age when they adopted her, her adoptive mother died when she was 12, and her adoptive father died when she was 14. Her best friend's mother raised Sue until she went to college. Sue has never married. She has a 7-year-old son. She had a long relationship with his father that moved from romance to friendship, but it was always one of support until he died last year.

Weight Gain and Overeating Experiences

Sue's responses to her weight gain were typical of many overweight people – an up and down battle of gaining and losing.

I went on these crash, low-fat, no-fat diets, and lost like 30 pounds and I was back to a 16, which I always felt comfortable in … but I still I wasn't skinny enough.

In her 30's, and especially after the birth of her son, the gain/lose struggle subsided.

I would go on diets and … I got to the point where I just, I think it was a lot of depression. I was depressed. I was single parent. I had this thing with trying to raise a

child, and I just stopped dieting, I stopped exercising, I stopped doing everything, and I just said, "well" …

During pregnancy and the birth of her son, Sue suffered from depression. The conditions were difficult: she was a single parent, her son was diagnosed with Attention Deficit/Hyperactivity Disorder, and the father was ill with cancer and eventually died. Sue's weight climbed to around 250 on a 5'2" frame; two years after her son's birth, she weighed more than she did during pregnancy. The burdens of single parenthood with a hyperactive child became weight on Sue's body.

So I thought a lot of his behavior problems were on me, so I think all that … I had it all on me, 'cause I'm the only parent.

For solace, she ate excessively. She took a break from dieting and exercising until her gynecologist told her that her cholesterol was a very high, and encouraged her to lose weight to lower it. Sue's supervisor expressed concern about her health and reminded her that she is now her son's only parent.

If something happens to me, you know, he's out there kind of alone, so, I need to start taking care of myself, because his father's gone on.

With these proddings, Sue began another round of diet and exercise, which was on-going at the time of the interview. As Sue made progress in her latest effort to lose weight, she has found that one day's slip-up can give rise to voices of doubt. She copes by joking about it. We laughed as she imitated that voice of doubt.

You slipped up today; you ate that double [laughing] hamburger from Checkers. I still keep that in the back of my mind, something back there saying, you know you're gonna mess up.

After the birth of her son, Sue developed a very personal relationship with food, especially ice cream, which often seemed to be her best friend. With her hyperactive son having behavior problems and his father dying of cancer, Sue felt alone.

> I didn't have a husband or anybody I could just cry out so, I just started eating. I--sit in the house, my whole evenings, my Friday - my Friday evenings, it would be just me going home with my Mayfield ice cream, but I look forward to going home eating ice cream on Friday night. I did! That was my Friday night date – Mayfield Moose Track Ice Cream.

Friends would tell Sue to get out of the house, but she felt a sense of contentment. She knew who she would be with. Food was always available and dependable, even as her eating led to more weight gain and more depression.

> I would get depressed about being so big, then I go and eat because I'm so depressed about being big and it's a cycle -- a vicious cycle, you eat the ice cream and you say 'well that just added another two pounds' and now I'm depressed again so I need to eat again, to make myself feel better.

Food symbolized reliability and dependability for Sue, especially when compared to her relationships with real people, such as her parents and the father of her child. They all took care of her, but then they died. Her son's father would respond to every request, getting her car fixed, helping pay bills and more.

> He just took care of me, so when he died, it was like, oh my God, another person's left me that I depend on.

This longing intensified her relationship with food. It was the one thing in life she could count on. Everything she loved and enjoyed seemed to vanish.

> But not food. Right, food can't leave you. It can't as long as you got some money to buy it, it won't leave you. People do, food doesn't. You've always got food. You know, so food becomes your friend. I never really knew, how much I depended on it, how much I depended on food.

Self Perception and Body Image

Sue's struggles with seeing herself as overweight began in adolescence and escalated in college. She recalled her weight problems during in high school.

> I've never been what you call a typical skinny girl. I've always had a weight problem. I was not the typical cheerleader size but I wasn't so big where I couldn't participate in everyday activities.

The belief that she had a weight problem, when she did not, distorted her self-image. As a teenager, she thought of herself as heavier than she really was. Her high school pictures revealed her as a size 12, "but you know I thought I was fat." Despite that feeling, Sue did a balancing act with her self image. She engaged in social activities and felt relatively comfortable going out.

In college Sue experienced weight gain followed by temporarily successful bouts of dieting.

> When I went to college, you know the stress of going to college, that's when it started picking up. But again, I lost it, I lost a lot of weight, I went on these crash, low fat, no fat diets, and I lost like thirty pounds and I got back to a sixteen which I always felt comfortable in a sixteen, fourteen, but I still felt like I wasn't skinny enough**.**

When Sue began her recent effort to lose weight, insecurity about her self-image emerged again. She worried about what would happen if she succeeded and reached her ideal weight. She recalled reading a Weight Watchers article about fear of success.

> What would happen if … I really start to really like myself? I'm beginning to feel like I like myself a little bit more. [But that wasn't always the case] I would look at my self and I would think, 'Oh my God I look TERRIBLE, I can't - I can't buy any clothes.' Ah, now as I'm losing – I'm still thinking that way and I'm still, by society terms overweight, but I know now that I'm doing something about it, so I'm not feeling as bad about it. So I'm [thinking] like what would happen … would I be a completely different person? So it kind of scares me, cause I kind of like the person I am now. If sometimes you're so comfortable with the way you are now, it scares you to think about what would happen if I changed drastically.

The possibility of drastic change was met with other societal or learned barriers. Sue's "typical Black features" contributed to her insecurities.

> I was dark skinned, had big lips, I always thought I wasn't pretty enough. I had kinky hair, the typical Black features. I never was the homecoming queen. I mean-- in school I was popular, I had friends and everything, but I didn't ever feel like I was pretty enough. I think the [lack of] self esteem came by just not feeling good about [my]self and they just kind of carried over through my teenage years.

Sue talked about Halle Berry as someone who is so often promoted as the epitome of Black women's beauty. Although Berry claims her African American identity, Sue pointed out she is racially mixed and therefore she is not the typical African American woman. A more typical African American woman, with whom Sue can identify, is Oprah Winfrey.

She has the African American features. And you know she had her struggles with weight, so if anybody is gonna be more close, it would be somebody like her.

Sue also admired Whoopi Goldberg.

That's why I love Whoopi, 'cause Whoopi don't care what nobody thinks about her and how she looks or what – she does her own thing.

The traditional standard of beauty, in Sue's own mind, led her to avoid meeting a man with whom she had developed a relationship on the phone. Sue repeatedly put off a face-to-face meeting, certain that this man would be disappointed. Her fear was heightened when a friend told Sue she had seen the man and reported, "Sue, he's not just a nice looking guy, he's gorgeous." Sue was sure this man would not like her in the flesh.

And so the day finally came, and he said I really need to see you, and he said, why is it that you don't want me to meet you, and I made up all these excuses, about I'm so busy and I just don't have time. He said 'I'm just going drive to [her town].' That day , I – I called him on his cell phone all the way up here and just begged him not to come.

Begged and begged and begged him not to come.

But Sue's fears proved unfounded. When the meeting she'd been dreading finally happened she "didn't see any disappointment in his voice and his eyes."

She attributed this unexpected outcome to the three months they spent on the phone, getting to know each other. The relationship grew based on something other than appearances. His comments to her during this courtship helped change her thinking.

I just think sometimes people don't get to know people first. And he said 'we all judge people by the first time we see them and you think oh my gosh, she's beautiful and she's got the best body. And then, you talk to this person, they're not anything. I had known

you for three months and I knew I liked you a lot on the phone'. And he told me on the phone, 'I don't care how you look, I don't care how fat - big you are. I just like who I'm talking to.'

The relationship developed into love, but could not continue because of physical distance. Sue had never told this man how much he helped her self esteem.

He used to tell me, 'I know you think that I'm not going to like you, you're either worried about [or]you think that you're too overweight for me or you're not attractive enough', he used to tell me on the phone. I like you for who you are.

Sonya

Sonya is a 54-year-old African American woman who lives in Alabama. She works in a nonprofit social service agency as the executive director. Her work involves advocacy for children and she has worked on social policy at local, regional and national levels. As a result of her work, she received a national prestigious award that recognizes creativity and potential.

She is married and the mother of two young adults. At the time our interview, Sonya was 5'4" and 257 pounds, with a BMI of 48, which placed her in the extremely obese category of clinical obesity. Sonya wore her salt and pepper hair in a short Afro. She was neatly but casually dressed. We met each time on a Saturday morning in the home of the colleague who suggested she participate in the study. She spoke in a soft, clear voice with clarity of thought. At times she seemed to take on a role different from interviewee. Although we were the only two in the room, I felt like Sonya was making a statement or giving a passionate speech. She answered the interview questions with a sense of knowing that came from self-analysis and self-awareness. A gentle sophistication surrounded her presentation of self, and her interest in the subject was affirming. I left the interview thinking that I had met a comrade.

Family Experiences

Sonya grew up in small town just outside of Montgomery, Alabama. She lived with her parents, who farmed the land where they lived. She was the third child of eight children, but Sonja believes that functionally she was the oldest.

> I look back on my childhood and I felt somehow, like a person who, I knew I wasn't a grown up, but I just felt this sense of responsibility that weighed so heavily [on me]. Maybe the food was a way of dealing with this pressure. I was constantly thinking 'if something happens to mom, I would end up having to leave school, quit school and take on the responsibility of caring for my younger siblings.' I have a sister that was older and actually a brother that was older, much older--somehow I saw the younger children as my responsibility.

Sonya had these thoughts as a preteen.

She had had rheumatic fever and asthma as a child. She remembered being a sickly child, who had to avoid the outdoors and the work the family did on their farm. She became her mother's helper with the younger children and with family meals. Her older sister envied her relationship with their mother and was in Sonya's eyes unnecessarily punitive to their younger siblings. This increased Sonya's sense of responsibility to them.

> The more I think about it, she [her older sister] probably resented very much the relationship that I had formed between mom and me, and felt outside of that and so she never saw the children and the house as anything that she would take on … [she would play with the younger children like she was their peer and not almost an adult] and then she would make an immediate switch into adult with them and the kids were thrown off

so she would punish them … and I always found that that was the one thing I saw as an injustice and I saw myself as their protector.

These early relationships with her siblings and mother set the stage for Sonya to carry more than her responsibility in many relationships. Her father became ill and her mom had to take on the field work, the farm and the home. Sonya saw her contribution to the family as the things she could do in the home and with the children.

Sonya has remained more connected to her family more than she wished to be. She has been a responsible caretaker for her older parents and a resource to her siblings. She felt overwhelmed and angry at times at the level of responsibility expected of her, and she struggled with ways to let go. She married shortly after college and has two young adult children. She was expecting her first grandchild. Her husband has some serious health issues that are exacerbated by his obesity; Sonya also helps care for him.

Weight Gain and Overeating Experiences

Sonya was a child who enjoyed eating and she had no inhibitions about the pleasure it bought her.

I was the kind of kid who loved to eat --and I didn't have very much willpower when it came to holding off eating. If mom said dinners ready I was first in line; I didn't just sit there and kinda wait until somebody else got up. I was the first one in line.

She was not overweight as a child, but she became aware of her weight and body size as a preteen and began her struggle with food and weight gain. By the end of high school she had begun to define time periods in life by her weight.

When I graduated high school I was weighing 145 … when I finished my uh sophomore year I was weighing 160 … finished college I was weighing 200 lbs -- when I married I

was weighing 220 … I was 250 pounds when it occurred to me that the real pattern of weight increase had started [in college].

She attributes her problems to a lack of willpower. Sonya had a voracious appetite and was chided by siblings for eating too fast and too much.

I just didn't have a whole lot of willpower around this eating thing. I was called things like greedy…that almost became kind of a little name.

When Sonya entered college she was put on hormones for debilitating menstrual cramps. She did not realize that the medication was a form of birth control pills. When a college classmate showed her that her birth control pill pack and Sonya's hormones were identical, she was furious. One reason she was angry was because she thought that the pills made her gain weight. Sonya expressed her anger to the doctor. Even though he responded by telling her that the pills were both hormones for her cramps and birth control pills, she felt violated. She traced the beginning of her weight gaining experiences to this incident.

We'd heard a lot about hormones, I mean birth control pills, and you get fat from them--and they cause cancer. I was thinking he could have at least had the decency to talk to me about what he was giving me. To be perfectly honest, it was about 10 years later, and 100 pounds later that I remembered that when I was put on those pills I was weighing about 145 to 150, and I just started this gradual increase. I didn't make a correlation with the pills at all, but about the time I finished my sophomore year I was weighing 160. I went to another doctor pleading with him to give me diet pills so that I could curve my appetite. I was just in hives; I was breaking out [at] 160. That was just ridiculous! I felt so fat and so overweight. I went on to transfer to a senior college, and by the time I graduated, I was weighting 200 pounds.

The time Sonya spent in college was fraught with weight loss efforts. Friends gave her gifts that were weight-loss-related like a spa membership. She went on a series of diets including the Atkins diet and the grapefruit diet. Each weight loss effort was rebounded with a weight increase.

> I saw myself really being affected by this obsession with weight; I saw myself getting bigger. Each diet that I went on and came off the end result, four or five months later, the total sum was 10 to 15 pounds more and I saw myself going up, being consumed, feeling inadequate.

She weighed 250 when she connected the beginning pattern of weight gain to the use of birth control pills or hormones. But she quickly returned to early messages about her greedy eating habits, and dismissed the experience as valid.

> I think I was about 250 pounds when it occurred to me that the real pattern of weight increase had started around the time I started taking the birth control pills or the hormones. [She told herself] 'That's not an excuse, that's nuts. I'm not even going to give credence to that. That's not an excuse, I am just undisciplined, I don't have self-control, and I am just greedy."

There was no doubt in her mind that she was really an overweight person now. Reactions to her weight moved beyond immediate family, self-conscious, Sonya began to apologize for her weight before others could comment.

> I'd walk on a plane, and I started seeing people hoping that I wouldn't [sit beside them] and I would sit down and apologize "Yup, I'm it. I know you were hoping not, but …" I now realize I was in a state of really beating up on myself about my weight and it was affecting my life and the quality of my life.

Sometimes the responses from others were more direct and surprising to Sonya:

> As a matter of fact, I serve on a board of women, and this was for my job and this was a pretty progressive board and feminists [were on the board]. We would get into discussions [about weight] and at times I would hear, 'this is not good for you, you know you really are damaging your health, you really need to do something about…' So everybody got into making me the project, of getting control of my out of control state, which was my weight, and I found that to be just disconcerting and certainly an erosion of my self -esteem.

Interactions like these brought up familiar feelings, feelings similar to the ones she had experienced around race and gender. She tried to make sense of it.

> I got messages from people and at first I was not sure whether it was my race, whether it was my gender, and when I heard it coming from other women I thought: 'ok, this has to do with my … this is not gender' so then I said 'it well may be because I'm a southerner, who is rural, who is grass roots.'

She tied her rural southern background to being overweight and to others' prejudices.

> And generally it seems that southerners are heavier and particularly non-African Americans are smaller … much smaller if they are not from the South. [She speaks of others doubting her ability because of the weight] Just a sense of 'how can you be this person who is offering guidance and leadership to others if you can't control your weight?'

As difficult as relationships with people can be, Sonya's relationship with food has been a consolation. Food is the friend who always understands. Sonya's relationship with food was

established early in childhood and manifested in her love of eating and what she perceived as a lack of willpower around it. She remembered taking her lunch to school.

> We had to take our lunch to school and by the first recess I had eaten mine, and if she happened to make teacakes I had eaten them before I caught the bus.

These sweet treats were pleasant memories during a childhood that was replete with adult responsibility. One of the ways Sonya supported her mother was to be responsible for keeping the money for bills. Her mother asked her to hold the money to assure it would not be spent. Sonya worried about the money. Food became a coping tool.

> I needed to be clever enough to come up with ways for mom not to come back and get this money. It was a constant worry and it ended up being a burden. The food became a kind of nurturing-- food for me was even then a way of dealing with this pressure.

The one food that Sonya enjoys most is ice cream. The battle with this food can be described as a love-hate relationship. Prone to eat it excessively, ice cream has contributed to her weight gain. It is also a food that triggers allergies. Along with chocolate, the milk in ice cream creates mucus in her lungs and causes serious health problems.

Ice cream, however, is only one of many sweets Sonya is drawn towards. She viewed her desire for sweets as obsessive at times and tied it to her family.

> My obsession is with sweets. I have a sweet addiction. My daddy had it, 80% of my family members are hooked on sugar. I drive myself very hard. I don't take time to eat meals on time or eat meals at all. I will grab an energy booster, which is sugar. I have gotten accustomed to when I'm really happy with something treating myself with some sugar. When I'm real sad, treating myself with some sugar. Sadness, you know just in a place of kinda down, boy look out that's some good chocolate, or some ice cream. Those

are the kinds of things I have used. I guess the word I hear now is comfort foods. I get comfort from them. When I am feeling depleted, when I'm feeling needy, when I feel I need nurturing, those are the things I turn to.

Self Perception and Body Image

Sonya's distorted thinking about her weight began in childhood.

As a child I always thought I was fat. I look back at my pictures and what I realize is that my sister, who was a year older, was skinny and she would call me fatso. Early on, I got rheumatic fever in the joints and I became asthmatic around 10, so I would get winded, that was perceived as [a result of my] eating. When I looked back at my picture of that age I was not an overweight kid. It began probably around age 10 to feel I was fat. In my mind I took on the idea that I was fat and clumsy because I would get winded.

This image stayed with Sonya through adolescence.

When I graduated high school I was weighing 145, and I thought I was the fattest person in the world. It was only as I got older and looked back-- I said 'where did that come from, that whole image in my head that I was so-o-o fat?'

It became a self-fulfilling prophecy as she gained weight in college and saw gradual increases through middle age. Her perception of herself as a fat person was a constant part of her thinking.

When I would walk into a room I was the largest person in the room; I was the heaviest in the room.

Sonya began to worry about what others thought of her, and she would collude with them in what she perceived to be put downs. She entered therapy to begin to deal with issues like this.

I remember being in therapy and really my eating, and how others saw me became really big issues for me. I was joining with others in making jokes about myself so that I could beat other people in what I thought they would say. I would be the first to say it.

She gave an example of how she did this.

> I heard myself in the doctor's office recently. I was doing this eye exam and I had to lean forward in an awkward position. I said to my doctor 'You need to hurry up now because there is certainly something her in front that is a barrier to my leaning.' indicating my stomach. And he goes 'yes I guess the Swiss didn't really take that into account' and he didn't finish, I said 'Oh no they didn't take in account we obese Americans.'

It was, however, the first time in a while that she had made a self-deprecating remark. She had been putting herself down for almost 15 years. It was a self-protective defense mechanism. Therapy helped her realize this and she began to change how she treated herself.

> I realized that I was in a state of really beating up on myself about my weight and it was affecting my life and the quality of my life so I was, as I mentioned, I was in therapy and finally began to really get to a place where I gradually began to accept me as being OK. The preoccupation with weight was other people's problem with me. I was not going to buy into that and I really do realize that in this country there is a preoccupation[with weight] and that people seem to have far more disdain for fat people than for other folk that might be doing things that are harmful to themselves. I feel like there is a phobia that is going on, that people at some level … that somehow or another [speaking of others] 'I might get this.' So my overweight seems to at some level frighten folk.

Sonya had begun to assess the early messages from her sister, the nonverbal looks of disapproval from people on the plane, and the unsolicited advice from colleagues. She decided that she had had enough.

> I basically stopped dieting. I just said 'no more, no more!' The honest to God truth, I was weighing at that time about 280. I have fluctuated back and forth with a 10 pound, no more than 15-pound [range], but it's been a weight that is not-- I seem to have gotten to a weight that is more of my-- I have accepted myself and not been caught up in the yo-yo of a diet and then moving on up and moving on up higher and higher. I think I know what the key is for my changing my weight and that has to do with valuing me, making room for me in my life, dealing with, addressing my care-taking role, my basic position in life of putting others first. Now I realize that those are issues that for me are important to address so that gradually my change in life style and my change in valuing me will in fact ultimately affect my eating habits and a weight change will be more of a stabilized weight.

She was also motivated to stabilize her weight for health reasons.

> I certainly want to be thin for physical reasons, for health reasons. I have found that the area where my health is affected most is with my knees, my joints. I've been told that the cartilage, because of my weight is wearing very thin and it's going to be a matter of time before I'll have to do knee replacement surgery. The weight is pressing on my spine. I'm beginning to feel so much pressure in my lower back. I am constantly chiding myself about 'you're gonna create a situation where you're gonna get cancer or have a heart attack or a stroke.' Fortunately I don't have high blood pressure, and I haven't had issues with diabetes.

She remembered that that was the only reason for which she would allow herself to verbalize a desire to lose weight.

> I always use to say 'I'm not worried about losing weight for appearance; I'm not into appearance. When it becomes a health issue, I'll make it a priority and I'll get really serious.' I think that coming from a poor family and the way I dealt with poverty was just to not want things.

Sonya, however, has had a lot of medical tests in the past few years. Her fears around her weight have caused doctors to check out any symptoms or pain she had more carefully. She knows that the foods she loves have exacerbated her lung condition caused by the asthma.

> My asthmatic condition is my most serious condition. I have had pneumonia, in my lifetime about three or four times, so I have a good bit of scar tissue in my lungs. I have to be very careful about getting sick with colds and bronchitis and so more I am discovering that the triggers for that are allergies and a good number of the foods that I eat are connected to food that I'm allergic to. Many of the foods I enjoy are not good for me as it relates to building up mucus and creating allergies that weaken my system.

Being sick reminds Sonya of those times in childhood when she could not play or help outside. She also did not like being dependent on her family members to care for her. She does not want to become the "sickly child" again.

> I don't want to depend on others. I don't want to be in that role that I was in so much as a child, where someone has to come and help me with heating pads on my knees, helping me to walk, helping me , rubbing my chest, trying to help me breathe. There was a lot of illness for me as a child.

While the illness was tied to non-weight-related health conditions, the physical discomfort associated with the weight she carries now reminds Sonya of that period in childhood.

Rhonda

Rhonda is a 43-year-old African American female who lives in a college town in north Georgia. She works as a social worker in a medical setting. She is married and the mother of four school-age children. Rhonda is 5'9''and 325 pounds and her BMI is 48, which placed her in the extremely obese category of clinical obesity. Rhonda had shoulder-length hair worn in a straight style. She was strikingly attractive with sharp features that appeared to combine African and American Indian traits. Her skin was chocolate brown. She had a rich gentle voice that soothed the listener.

Rhonda came to the interview at the end of a workday, neatly dressed in flattering office-casual attire. She had just dropped one of her children off for an extracurricular activity. We met in my office at Rhonda's request. She was thoughtful throughout the interview, without premeditated ideas. She relaxed as the interview progressed, sharing more of her feelings than thoughts towards the end of the interview.

Family Experiences

Rhonda is the fourth of five children. She has two sisters, one older and one younger, and two older brothers. Rhonda was born and lived in early childhood years in a northeastern city with her mom and dad. Her parents were from a small southeastern town and returned there when Rhonda was a preteen. Rhonda's mother was a stay-at-home mom, while her father worked a blue collar job to provide for the family. She said her mother sold Avon, encyclopedias and yearbooks for extra money.

Rhonda's fondest childhood memories of home were laced with gatherings around food, and home cooked meals made by her mom.

> My mother was an excellent cook and when I was growing up my house was always the gathering place for entertaining so it always meant fun--it also meant comfort. I walked to school and I still remember it, she [mom] made little sandwiches and soup. And then on Saturdays it was her special day --on the weekend she made pancakes, waffle--it was her way to show she cared and took care of us.

There was a pattern in Rhonda's family that established the mothers as nurturers through food and good home cooked meals. Her mother learned this from her grandmother, and Rhonda followed her mother, cooking and eating were ways to connect.

> I remember going to my grandmama's house and she and I would get in the kitchen and make a cake and she would show me how to churn butter. She had a wood burning stove. It was a way to get to know her. We didn't sit down and talk about her life, her childhood --it was in the kitchen, we weren't in the den, the living room. She [grandma] talked about how her mom taught her how to make something. It was a connecting.

Rhonda married while in graduate school and had four children. She, like her mother, is an excellent cook who views her culinary talents as a gift to her family.

Weight gain and Overeating Experiences

Rhonda thought her was normal weight until her late teens when her family started commenting on her weight gain. They encouraged her to have smaller portions and to eat less.

> The first time I remember feeling like I need to think about my weigh is probably in late adolescence where family members would make comments like 'you better watch your weight' or [regarding food] 'push back.'

Rhonda did not really understand what they meant or how to address it, so she did nothing. She did not think she had a weight problem.

> In high school people were attracted to me, I was never picked on or criticized because of my weight in high school. So I went through high school ok.

During her freshman year in college, however, she was rejected by men and she did not date much. Her girlfriends told her she would have to lose weight if she hoped to get attention from men. She decided she would do something. She went home at the end of the school year and joined her mother on a diet plan.

> I thought 'man I guess I better do something about my weight.' About the same time my mother was going to a physician who put her on diet. That was really the first time I had access or knowledge about what somebody said to do about gaining weight. So I went on a diet, the one her doctor gave her, and [I] loss 45 pounds.

Part of Rhonda's motivation was that her girlfriends had seen her rejected by men. The humiliation she felt because of her weight made her more determined to lose it. This 45-pound loss occurred between her freshman and sophomore years. With Rhonda's change in appearance, men gave her as much attention has they had rejection the year before. She resented their change of heart. She knew she was the same person, and she wondered why they couldn't see it.

This was a difficult experience but Rhonda laughed as she recalled the sweet revenge of weight loss.

> So I loss weight and then I went back to campus and all the attention from the boys and then I was like… I don't know what the right word would be…resentful that they didn't [see me], to me I was the same person, and I was inside I had the same bubbly personality

(laughs), uh morals, everything about me was the same, just the outward package was more appealing, and so I spent a lot of time being …I guess they would have called it 'stuck up.' Especially to guys who would say 'when did you get to campus?' and I had been on campus; 'did you transfer?', like they had no recollection that I had been on campus, I was really mean to them (she laughed).

Rhonda kept the weight off through college and graduate school, and early marriage. She had never been away from her parents' home except for college and now she was independent. She noticed an increase in the weight when she started working. Now a clinical social worker, Rhonda started working in the local mental health center. She found the job to be very stressful. She worked with severely mentally ill people and at one point she had to deal with a stalker. She coped by excessive eating.

I worked in mental health and it was a zoo and I happen to work with people who taught me that food was a big stress releaser. The culture I worked in gave me permission to eat because that's what we all did when we were stressed out, after we would see clients or it was a long day. We would each take turns, including the boss, buying ice cream. The boss would buy three-and-a-half gallons and bring it to work, at holidays people would bring food, duck a la 'range, I mean elaborate spreads. There were only like six or eight people in the office and we would have enough food for twenty. It was all stressful. I mean we would do crisis walk-ins. Just the fact that you were had a lot of cases and a lot of paper work. [It was] just a stressful atmosphere -- a schizophrenic client was stalking me.

When Rhonda found out that she was pregnant, she gave herself permission to eat for two.

> Then I got pregnant, people start saying you can eat now 'cause you're eating for two. The first time I got pregnant I miscarried so when I got pregnant very shortly after the miscarriage and I was scared. I started having some problems with that pregnancy, started bleeding, got put on bed rest and I pretty much stayed in bed-- didn't move around and ate. I realized that was stupid, 'I'm not eating for two. I'm gaining too much weight'. I think I gained 60 pounds with that baby.

She lost weight after that pregnancy. Rhonda had three more pregnancies. She lost some weight after each, and she never gained as much weight as the first one. But the successive pregnancies and responsibilities of parenting made it difficult to maintain an eating and weight loss program. At one point, Rhonda became a stay-at-home-mom and, she gained weight again.

> I decided with four kids under eight were too many kids and too young for me to be working -- so I quit work -- I quit public work and started working for myself -- and staying home with the kids, but that really just took me out of the loop of everything interesting and exciting to me and I just became pretty much mom, accessible to the kids, helping them with school--you're bored-- you eat.

After three years Rhonda returned to the public work force-- her challenges with weight returned.

Although Rhonda is clear she wants to lose weight, weight loss means giving up a relationship with food that she values. Rhonda's relationship with food began with the pleasant experience of eating her mom's home cooked meals, and learning how to bake and churn butter with her grandmother. The family gatherings in her home meant that food would be plentiful. She also associated food with comfort, such as the times when her mom made special meals for them on the weekend.

Rhonda's enjoyment of food has often been tied to a relationship or event. At her first job, she and her colleagues ate to handle the stress. Food was a reward or method for coping.

> The stress at work was like battle camaraderie. We were all in the struggle together against all this work and clients. This was a way for us to be comrades, break bread together.

She connected her relationship with food experiences in the church and culture of the African American community.

> Well I think the culture of the Baptist church, feeding, feast days is a part of the African American culture. I think resources have always been short [for African Americans], so feasting was one way for people to share their resources and for everybody to bring [food] and share with each other.

Rhonda did have one food to which she was attached and that was sugar. She was put on a diet during her third pregnancy that eliminated sugar. She found that she really missed having sweets and grew to resent having to give them up.

> I was on this diet that I wasn't eating any sugar. During that time I was pregnant, the third. That may have accounted for why I didn't gain a lot of weight and I got tired of it! I enjoy sugar, I like things with sugar, and I gradually started eating things with sugar. I'm beginning to believe the more diets you go on the more weight you gain.

Self Perception and Body Image

Rhonda has this to say about her body image:

> Well I think my mental image does not match up with what I look like--I don't look--I'm sure I mentally suppress it with something that's more in line with what I want to look like. I do not if I can help it, undress around anyone.

Rhonda's mental image of herself has been distorted most of her life. As a preteen, she did not understand why her family members thought she needed to eat less. She was shocked to hear the reactions of others in college, and she was hurt by sibling comments like "Girl, you look like a beached whale." Rhonda's brother would send her crying from the room with his tactless comments. She said that she has forgiven him, and he has become a kinder person. But she has been scarred by others' efforts to confront her about her excess weight, or their perceptions that she was overweight. There were times when she was not overweight, and she had become weight conscious because of concerns expressed by others. This created a distorted sense of self that she is now realizing was inaccurate. She reflected on an incident that occurred when her brother had a girlfriend visit.

> The summer before my senior year, I met a girl he was dating, she said 'you're so beautiful,' he said, 'yeah she's loss weight, but she could lose more.'
>
> She looked at pictures from that time period.
>
> When I look at those pictures I never thought I was there at the point I want to be, cause 200 pounds less than I am now, I never thought I was where I needed to be … inside me, I never thought I was quite good enough. I guess I thought in my minds' image that I never got there. I don't know what that number is … even at 140, when I look back I think I was too thin, I was very thin and I remember thinking I was fat then.

When Rhonda stayed at home with her small children, she became more comfortable centering her attention on her role as mom and homemaker and away from her weight concerns. Rhonda's primary focus became providing a nurturing environment for her family. She now had time to hone her cooking skills, and she had a sense of pride and enjoyment doing this. Rhonda

associated this with being a good mother. She shared a time when one of her children asked her to cook.

> When I asked her what she wants to eat she says 'Momma, I just want you to cook.' That says she wants me to take care of her. She wants to eat something home-cooked; she doesn't just want to drive through. She wants me to be "mom." It is a positive way for me to take care of my family; I mean the act of cooking the science of cooking, of putting things together of making them taste good, the creativity …

These were positive images Rhonda had of herself. She believes she is fighting an uphill battle with the weight and her self image. The community accepts overweight in the African American woman normal. She thinks that as African American women age, it is almost expected.

> I think there is generally acceptance in the African American community for being overweight, I don't remember too many skinny grand mamas, everybody's grandmamma was big mama 'cause she was a big mama (she laughs). It would have been stranger to see someone's skinny grandmamma.

The cost to being overweight has affected other aspects of her body image and abilities. Rhonda found she faces more physical challenges and illnesses. When asked about health or physical problems related to the weight, initially Rhonda said she didn't have any. As she thought about it, she started to talk about her knee pain.

> I've had pain in my knees and I went to the doctor and he told me it was directly related to my weight. He actually told me that it was going to kill me. For one, I thought he was just picking on a fat person, and [laughingly, as if talking to the doctor] because you're

skinny you're gonna tell me I'm fat, you just a bone specialist, you don't know. He ain't my regular doctor.

She went on to share that she had also developed high blood pressure, but the denial of her weight gain problems caused her to ignore a potentially serious condition.

So I had that, then I had a recent high blood pressure reading. Well I loss 30 lbs and she [Rhonda's doctor] told me my blood pressure was fine and I could come off the medicine. I've actually gained that weight back but I haven't checked my blood pressure again.

Gloria

Gloria is a 49-year-old woman who was born and grew up in middle Georgia. She lived most of her adult life in the same town. She is twice divorced and the mother of five children and the grandmother of 11. Gloria spent her early adult years raising small children, and barely surviving as a single parent. She attempted to complete her college education several times, but faced innumerable obstacles until most of her children were grown. She had completed her bachelors and two masters' degrees in the previous seven years. She has worked for over a decade in some form of human services, and she now works in a private practice as a professional counselor. At the time our interview, she was 5'8" and 241 pounds, with a BMI of 37. This places her in the obese range of clinical obesity.

Gloria met me at my office during a work break on two occasions. She did not want to meet in her home because she wanted to do some repairs before she had guests over. Her children frequently visit, and one of her youngest children lives with her. She thought we would have more privacy in my office.

Gloria has medium brown skin with almond shaped dark brown eyes. She wore a curly dark brown wig to the first interview and wore her own off-black hair in a pony tail for the second. Both times she was neatly dressed in professional attire. She announced in the first interview that she had a limited time to spend. She spoke easily; she hesitated only when she was thinking about the question and at one point when she was discussing an experience in life that was painful to remember.

Family Experiences

Gloria was the fifth of 10 children. Her twin brothers, however, died shortly after they were born. They were the oldest of the 10 children. Gloria grew up with seven siblings and she was the third oldest of this group. Of the seven, six were girls. Some of Gloria's siblings had different fathers, but her father was the only man her mother married. Until she was three, she lived in a two-parent home. Gloria recalled the day her father left and the sadness she felt. She did not see him much in her childhood because her mother refused to let her visit him and he did not fight to do so. In late adolescence, she learned that when she was a young girl, her father wanted to take her and raise her. She also learned he was gay, which may have accounted for the unexplained estrangement between her parents.

Gloria was a tall girl and she said family, teachers and community folks called her large. She was, in fact, an average to under-average weight, but because she was tall she was called large.

> Most of my life I always been considered large. In my family I always have been considered large. Although you know at 127 [pounds] I was hardly large. Even when I was small, because I've always been tall. I've been 5'8" since I was probably in … ninth or 10th grade and somewhere between 119 to 120 [pounds].

Gloria said that she was teased about her weight as a child, before she reached high school. Her sisters were the main culprits. She believes it was because they were thinner than she was.

> … you know how sisters are. My sister would say things when I was about, when I was, before I was 12. Just stuff [speaking of what they would say] 'ole big Glo', you know -- cause they all call me Glo (laughs). So, but anyway, yeah just stuff like that. [They were] extremely cruel, but you know sisters can be that way.
>
> Her sister's comments convinced Gloria that she was overweight, and she felt badly.
>
> Well, I-I, it always made me feel really, really conscious of the fact, that I was [overweight], you know, cause most of my sisters, with the exception of one of my sisters, they were-- they were really thin. And they continue to be thin, or most of them. And, ah, so it – it was always –it was a put down, yeah. It was a put down, basically. It would make me feel, I – I don't think I ever felt angry. I felt, you know I felt bad, I felt bad, you know that I was bigger than other people, or that, you know I always felt like, you know, I just felt sad about it.

Gloria was raped by a family friend at the end of high school, and she became pregnant with her first child. Her mother helped her care for the child initially, but frequent arguments lead to Gloria leaving and going to live with her boyfriend and future husband. She married and had four more children; her last two children were a set a twins, a boy and girl. Interestingly, she had only one boy, mimicking the gender makeup of her family of origin. This marriage ended when her children were still small. Her first husband was controlling and physically abusive. Gloria married and divorced two other times. She has spent most of her adult life as a single parent. She said she felt, despite numerous challenges, she has been a good mother.

Weight Gain and Overeating Experiences

Gloria kept her weight down during adolescence with extreme dieting and exercising until she was in her mid-twenties.

> I would go on these diets where I would eat, you know, very little food every day. I eat like a boiled egg in the morning and then some salad and that was probably the—what I ate for the day. So if I felt like I had gained five pounds, I'd lose. I'd go on a diet and I'd lose, I'd lose the weight really as quickly as I could.

With the exception of pregnancies, she did not gain much weight until she divorced her first husband. Her weight and eating were controlled by her first husband's demands that she not become fat. As she tried to meet his demand by staying thin, the earlier practice of losing weight as fast as she could served her well.

> I'd lose the weight really as quickly as I could, especially, during my first marriage. I mean, he, his thing was always, 'I'm not going to be with a fat woman, I'm not … and you know 'you're getting fat or you're fat.' The thing that was so funny was like, he would always tell me that I was fat, but I was so thin at one point that my bones were basically jutting out. Then he got mad because when we were having sex, I was hurting him, my bones were hurting him. And I'm like you know, you can't have it both ways, you either want me thin or you don't want me to be thin.

Gloria's motivation for losing weight and staying thin was how he felt. If she began to gain weight and he was displeased she would immediately start a diet. Sometimes she just did not eat, and she would exercise habitually.

She gained about 10 pounds after she divorced her first husband. It was the first time she felt free to eat as she pleased. Gloria tied her next weight gain to the end of her second marriage.

Her second husband chose to leave and she sunk into a depression that led to a weight gain of about 60 pounds.

> I gained a lot of weight. Well, I actually experienced what was considered a major depressive episode. And actually the whole time I've been - all my life I can remember that, if I got really, really, really sad, I would just eat. So, but during this period when he left me, I was real sad. So the first few weeks I just kind of stayed in the bed. And then, ah, when I did get up I would just go stand in front of the refrigerator and eat until I hurt. I just ate until my stomach hurt. Then, I'd go get back in the bed … and I gained 60 pounds. I didn't do anything else. I didn't work, I didn't do anything.

Gloria eventually realized she was again being controlled by a man. She decided to lose the weight.

> I said 'I'm gonna lose this weight,' because – really, like I'd never been that heavy before. Actually when I had my twins, I weighed over 200 pounds, but I went right back down to a 145 shortly after they were born. So I'm like I'm gonna lose this weight, because this is ridiculous, you know, that I'm allowing somebody to have that much control over my emotional well-being. I did, I lost 30 pounds. Actually, I kind of got a little bit obsessed, and I started walking. I was walking like five miles or something a day. But I lost it. And then I gained it back, and I gained some more. But I've been almost constantly unhappy for a long time.

Self Perception and Body Image

Gloria's self image as an overweight person was formed from the messages that she received in childhood around her weight and body size. She became pregnant at 15 after being

raped, but experienced the negative consequences of teen pregnancy that were common to her generation.

> If hadn't been raped at 15 … in the 10th grade, I could've done school stuff. Instead I was sent to a special school, but I graduated on time. The rape deprived me of experiences in high school I was looking forward to.

Gloria was not allowed, by the school, to be a cheerleader or participate in extracurricular activities because she had had a child. She had big thighs and large hips, physical characteristics that were considered attractive by the African American community and physical traits that would have made her more likely to be selected.

> Black cheerleaders were the girls with the big thighs and butts, and as a girl I had big legs. My grandma had big pretty legs … she would tell me 'girl if you got them you gotta show them'. I always had pretty legs.

Gloria said the limits that were imposed on her because of early motherhood shaped how she saw herself for a long time. It didn't matter that the pregnancy was the result of a rape.

> You were responsible. You were the keeper of your virtue, which created a whole other dynamic in my life. I became the girl that nobody would want. Sex took on a whole other thing for me. Sex was different; my whole concept of my humanity changed. The only thing that would make me special was to look a certain way to attract another guy. My first husband told me I was nothing without him, so pleasing him was first and foremost. Basically what he said was that I was not desirable to anyone else because I had a child before I was an adult.

These experiences contributed to Gloria's conclusion that her personhood was connected to how she looked.

> I use to think that who I am and how the world perceived me was linked to the way I look physically. I really use to, and sometimes I still think, you know, people think that I'm lazy or I'm incompetent or I can't manage my life because I'm overweight.

Gloria admitted that sometimes she still thinks that way, but she does realize that she is more than her body and she doesn't want that kind of thinking to get in her way.

> I can't allow that to keep me from doing the stuff I need to do. Because I know that I'm a good time manager, I know that my brain capacity to do the thing that I need to do is not likened to my body size. I'm not as agile as flexible as a person who is smaller.

She has been aware of people making facial expressions that are judgmental of her weight.

> Sometimes I look at people and they look at me, it's so funny because I don't think of myself as grossly obese. I really don't. I mean the person I feel like is still the same person I use to be. I just know that I am [overweight] because other people make me aware of it. My mom's always telling me about new diets. My sisters are always sending me e-mails about things that I can do and lose weight. Actually, one of the kids I was with the other day said something about me being chubby [here she is referring to a child she was seeing in a work setting].

Gloria does see that her weight has limited what she can do physically. She cannot dance or move as easily as she used to, and she is often tired. She shared that her doctor has asked her to lose weight, but she is happy she does not have high blood pressure or cholesterol problems. She has begun to accept herself, and she has reached a point in her life where the opinions of others matter less.

> You know in all honesty, I really like myself. You know, cause all the stuff – cause, you know this body has put up with me, you know and all the seesawing, all the dieting, all the

> crap, you know all the torture, all the punishment that I've done to it. And even now that I'm overweight, you know, it's still keeping me upright, getting me from point A to point B all the time, so you know it's my body, I really appreciate my body. I really wish that I could do it better. That I could take better care of it, but I just, you know, walking -- walking more often, doing the stuff I need to do.

Diana

Diana's job is near my office, so we agreed to meet during the work-day in my office. She was dressed neatly and professionally. She came on her lunch hour. Diana has worked for 30 years as a secretary. She displayed an air of confidence, yet she was down to earth and friendly. She is a tall medium-brown-skinned woman. She had a thick head of black hair that she wore in a layered straight cut. She has high cheek bones and an endearing smile. She is very attractive. She wore heels that made her look even taller. At the time of our interview Diana was 5'8', 325 pounds, with a BMI of 49. This placed her in the extremely obese category of clinical obesity. She sat throughout the interview in a rather formal stance, and thoughtfully responded to the questions. She admitted she wants to address the issue of weight, but has never given much thought to the reasons for being overweight. She seemed to be thinking about the subject for the first time.

Family Experiences

Diana grew up at home with her mother and father, who farmed the land that on which they lived. Diana's father died when she was a nine years old, and she was raised by her mother. Diana was the third child born in a family of seven children. She had one brother, her oldest, to die at birth before she was born. A younger sister died in infancy. Functionally, Diana was the second child and the first girl. That role seemed to carry a level of expectation from the family.

She has been the most responsible of her siblings, and she is often the one that everyone turns to for help or support.

> Diana did not recall much family history relating to her weight gain.
>
> Growing up weight wasn't an issue, never came up. But, as I got in high school you might hear a guy say 'she's kind of heavy.' It was mostly the girls, girls were more critical than boys.

Her family didn't say much about her weight, but eventually her mother brought it up.

> … she calls me 'Mama,' she'll say, 'Mama, you need to lose some weight … Mama I want you to lose some weight … you look good, but I want you to lose some weight, 'cause you need to lose some weight' … 'you look good, but I want you to lose weight, cause you need to be healthy.' She says that weight is not good for you.

She said that her younger brother used to tell her not to gain weight.

> 'because them men don't want a big woman.' And I'd say, 'Honey, look around, you got men want big women as well as little women.'

Diana never married, and she became a single mother at 25. She has had very little support from the father of her daughter. Although she did not speak of a strong connection between excess responsibilities and her weight, she realized during our discussion that she was always busy trying to do things for others.

> I'm the one that everybody comes to … if something is going on, they'll come to me

Diana's family responsibilities included taking care of her niece until she reached puberty. She treated this niece her like she was her own child. Unlike Diana's own daughter, this niece gave her a lot of trouble. She was prone to misbehave, had problems in school, and was manipulative and disrespectful. Eventually, Diana sent her to live with her mother.

With the exception of leaving home for technical school, Diana has lived with her mother all of her life. She believes that what was initially a haven for her has become a place of refuge for her mother. At some point Diana decided to stay home to care for her mother as well.

Weight Gain and Overeating Experiences

Diana noticed that she had gained weight in her teens, but she did not see it as a problem. She weighed about 170 pounds and was 5'8''. She remembers giving it some thought when a man she was dating commented:

> '… you're fine [good looking], but you know you could lose a little weight – you could stand to lose a little weight, but you're fine.' That probably made me think … now that I think back.

About a year after her daughter's birth, Diana started gaining weight. At around 212 pounds, she became concerned. She told herself she had to do something to lose the weight. She was successful at her first weight loss effort.

> 'Lord, I've got to lose over 30 pounds,' and I think I probably got close to it.

Diana got down to about 180 pounds, but not back to the 170 of her teenage years. She then gave up the struggle for several years and focused on being a mother.

> I just decided … I was going to be the type of mother that I didn't want men coming in and out of my daughter's life. And the weight just started coming on without me even noticing it, you know. It wasn't a big deal with me about what I weighed … my size and everything. I always tried to be dressed nice and look nice, at least to myself.

I asked her if she connected the two, raising her daughter without men in their lives and gaining weight.

I don't know, I really don't know. I wonder – if I have to think about it, I guess maybe. I kind of let myself go. I wonder if, I – I thought about this – I really have, I wonder if maybe in that I wasn't letting – you know I wasn't having anything to do with men, you know, wasn't – didn't have a serious relationship and there was a lot of baggage between my baby's father and me to – that I think I carried that around a long time and that probably had something to do with the weight gain too, because he was just a - - you know he wasn't a part of her life – didn't take care of her, and just you know, he was a total let down, a total disappointment.

This disappointment was traumatic for Diana, and she didn't let anyone know how hurt she was by his behavior towards their daughter.

So it took me a while to get over that. Ah, nobody probably, nobody knew, how I was feeling inside, but _ I didn't show it … oh no, no, no, no. So, that may have been when the weight started coming too, but you know I made up my mind I was going to be a good mother to my child. Ah, you know I can't even remember when the weight came only that it came – it was there.

Discovering high blood pressure, and a gall-bladder operation, made Diana aware of her weight problem.

I made up in my mind that I really needed to lose the weight because I wanted to be around to see my child grow up.

She started walking and watching what she ate, and lost about 20 pounds. Diana lost the weight before gall bladder surgery. Her healthy routine of walking and dieting slipped away after the successful surgery. When asked what changed, she couldn't pinpoint anything.

> I can't remember anything that stands out other than time constraints and not having a walking partner.

She began to gain the weight back, and became concerned more recently as other health concerns arose. She said she was not aware at first of physical problems from her weight, but did notice them now. For instance, she had been having trouble putting nail polish on her toes and trouble getting up after sitting down. Diana tires faster than others. It is particularly challenging keeping up with her long-legged daughter.

> The weight definitely makes a difference; it's a struggle to keep up and to be, you know … to be active.

Diana did not describe a strong relationship between feelings and food, except to say she will not eat when "really down." Boredom, she recalled, can inspire her to "eat, eat, eat." She loved starchy foods, such as potato salad and potato chips. She also liked to try new foods. She said that her weight gain was the result of limited activity and no restrictions on eating.

> I come home, lay on my bed, get to my desk, and I walk from my door to the car. The only physical activity I get is cutting the grass every couple of weeks. I think my weight comes from poor habits, late night eating and no activity.

Diana also said she did not get enough exercise because she has not made herself a top priority. Taking care of others took precedence over caring for her self.

Self Perception and Body Image

Diana laughed as she admitted that the reality of being overweight is not congruent with her self-image.

> When I think of myself, and I see a picture of myself, those are two different people. For example yesterday, this guy brought this picture by for me that he had taken at our class

> reunion and he left it on the desk; I wasn't in there. And I came and I saw it and I looked at it, I say 'who is that?' I knew it – I knew it was me, but it's just amazing how you view yourself, you know, in your mind, how you see yourself. When I think of myself, I pretty much think of that high school girl … that size and everything, but when I see myself I don't see that.

Diana acknowledges a disconnect between reality and how she saw herself. She moved from that denial to a stark truth that she is overweight. And while she said she knew overweight women can be good-looking, she questioned her own attractiveness when people complemented her appearance.

> People say 'you look nice' and I'll say to myself – who do they call 'look nice.' Is that a joke? Are they trying to be funny? And even, you know, like my daughter might meet in church sometimes, she'll come home and she'll see me in church and she'll say 'mama, you look so good' and I'll say, 'what kind of eyes does she have?' 'cause I don't see all of that.

In talking about the possibility of being both overweight and attractive, Diana seemed confused.

> Well, I don't necessary think I look nice, I think I could look better,(laughs) but, I …you know, we're condition to think that if you have weight, then you don't look nice, you're not attractive, but you can be with weight … even though it's weight, it's not healthy.

Diana's weight has also led to what she called a "running joke" about her clumsiness.

> Say I go on a church picnic, I'm gonna get out there and play baseball, I'm gonna get out there and play volleyball, I'm gonna play tug of war and all of that and I'm gonna always fall – that's a running joke about me,

Her resilience also shows through as she responds to this joke.

> … when we go places, 'ooh Diana's gonna fall, yall look out she's gonna fall.' And I always fall, they know it, but I get right back up and keep going.

Diana saw herself as someone who takes charge of her life and doesn't let much get to her. She works in a demanding office that requires multi-tasking, she is an active resource to her church community, and she cares for her mother and extended family when she returns home every day.

Diana shared that she had been sexually molested as a child by a family friend.

> At that time I knew nothing about sexual relationships or anything, but I can remember it being a dirty feeling, … and you know, a – just a – a, just a, I mean when I thought about sex after that, I thought ooh, that's just – it was just straight dirty. .And then I kind of think that's an appropriate word for how I feel.

Discussing the issue in the interview, Diana realized she had never given those feelings much thought during her sexual experiences. She has come to realize she was someone who didn't see a need for sex.

> I pretty much have the attitude that you don't need sex. It's – what's the big deal about it. But I don't if it comes from that or what [the sexual molestation]. But it's clearly something I can do without.

CHAPTER VI

SUMMARY AND DISCUSSION

The purpose of this study was to describe and examine the emotional linkages to obesity and overeating in African American women. The research questions that guided this study were:

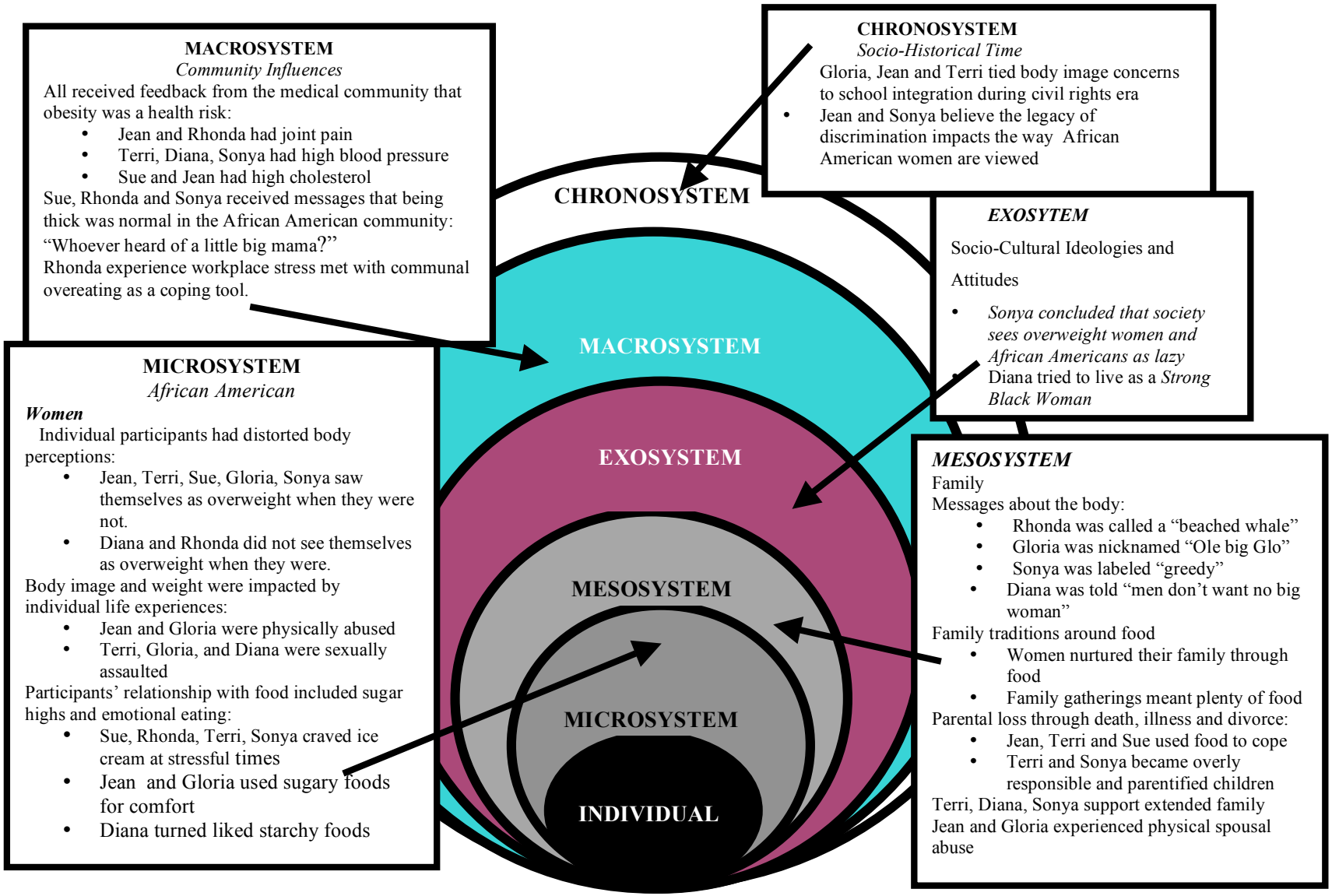
1. How do African American women describe the experience of being overweight?
2. What is the relationship between emotional stress and overeating in African American women?
3. What life experiences impact the outcome of obesity in African American women?

There were seven participants: Jean, Sonya, Sue, Rhonda, Gloria, Diana and me. All of us reside in the Southeast region of the United States. Our age ranges are from 41-57, and our BMI's range from 35-49. Two of the women are single and have never been married, two women are divorced, and three women in the study are married. All of the women in this study are biological mothers, and two have adopted or foster children. All participants worked outside the home, five in professional positions and two in support roles to professionals. Their position titles are listed in the demographics table (see Table 1). A number of issues and themes emerged as I reviewed the transcripts of each participant. The themes were used to create narratives of the participants, and they were applied to the theoretical framework (see Figure 2).

Table 1: Participant Demographics and Personal History

Participant	Years Obese	Age	Age at Onset of Obesity	Height	Weight	BMI	Relation-ship Status	Number Of Children	Job Title	Violation	Losses in Childhood
Terri	25	49	24	5'8"	324	49	Married	2	College Professor	Sexual Assault	Death of Mother
Jean	15	57	42	5'5"	254	46	Divorced	2	College Professor	Spousal Abuse	Death of Mother
Sue	15	42	37	5'2"	191	35	Single	1	Research Assistant		Death of Mother and Father
Sonya	30	54	24	5'4"	257	47	Married	2	Agency Director		Father Illness
Rhonda	20	46	26	5'9"	325	48	Married	4	Social Worker		
Gloria	17	50	33	5'8"	241	37	Divorced	5	Counselor	Spousal Abuse, Sexual Assault	Parental Divorce
Diana	25	50	25	5'8"	325	49	Single	1	Secretary	Sexual Abuse	Death of Father

Figure 2: Conceptual Model of Emotional Linkages to Overeating and Obesity in African American Women


MACROSYSTEM
Community Influences
All received feedback from the medical community that obesity was a health risk:
• Jean and Rhonda had joint pain
• Terri, Diana, Sonya had high blood pressure
• Sue and Jean had high cholesterol
Sue, Rhonda and Sonya received messages that being thick was normal in the African American community: "Whoever heard of a little big mama?"
Rhonda experience workplace stress met with communal overeating as a coping tool.
CHRONOSYSTEM
Socio-Historical Time
Gloria, Jean and Terri tied body image concerns to school integration during civil rights era
• Jean and Sonya believe the legacy of discrimination impacts the way African American women are viewed
EXOSYTEM
Socio-Cultural Ideologies and Attitudes
• Sonya concluded that society sees overweight women and African Americans as lazy
• Diana tried to live as a Strong Black Woman
MICROSYSTEM
African American
Women
Individual participants had distorted body perceptions:
• Jean, Terri, Sue, Gloria, Sonya saw themselves as overweight when they were not.
• Diana and Rhonda did not see themselves as overweight when they were.
Body image and weight were impacted by individual life experiences:
• Jean and Gloria were physically abused
• Terri, Gloria, and Diana were sexually assaulted
Participants' relationship with food included sugar highs and emotional eating:
• Sue, Rhonda, Terri, Sonya craved ice cream at stressful times
• Jean and Gloria used sugary foods for comfort
• Diana turned liked starchy foods
MESOSYSTEM
Family
Messages about the body:
• Rhonda was called a "beached whale"
• Gloria was nicknamed "Ole big Glo"
• Sonya was labeled "greedy"
• Diana was told "men don't want no big woman"
Family traditions around food
• Women nurtured their family through food
• Family gatherings meant plenty of food
Parental loss through death, illness and divorce:
• Jean, Terri and Sue used food to cope
• Terri and Sonya became overly responsible and parentified children
Terri, Diana, Sonya support extended family
Jean and Gloria experienced physical spousal abuse
CHRONOSYSTEM
MACROSYSTEM
EXOSYSTEM
MESOSYSTEM
MICROSYSTEM
INDIVIDUAL

Summaries

Jean's experiences with weight and overeating span a lifetime. She has fought the weight battle with diet, exercise, weight-loss groups and nutritional literature. She recognized the struggle as one that impacts her relationships with her family, men, and herself. Her experiences included physical abuse by her spouse, divorce, and single parenting. She believed African American women are more prone to weight issues because of the lack of nurturing they receive at home. She has stopped cyclical weight gains and losses, but still wanted to lose weight to become healthier.

Sue has spent over 20 years struggling with weight gain and overeating. She juxtaposes these struggles with a series of significant losses and stressful life events including the loss of her parents. Sue used overeating and unhealthy food choices to cope with the emotionally stressful times. Of late, she has reached a point of insight that helps her make healthier choices, exercise and take care of herself. She believes she has reached a turning point in this struggle.

Sonya has spent most of her life struggling with weight-related concerns. When she was not overweight, she perceived herself as overweight. She used food to cope with difficult situations and as a pleasurable life experience. She has tried to gain insight by seeing a therapist and by looking at early messages and behaviors that have contributed to the problem. While she is still overweight, she has come to a different understanding about her body and weight. She is no longer gaining and losing weight in an unhealthy cycle.

Rhonda did not believe she had a weight problem until college. She began to battle her weight at the end of her freshman year of college, and she continues to lose and gain episodically. Rhonda tied her weight gain to both work stress and her role of family nurturer.

She admitted to periods of time where she denied the realities of being overweight by focusing on others.

Gloria's life experiences affected her body image and weight, including physical and sexual abuse. Additionally, she heard messages from her siblings, her teachers, and her first husband that she was large or fat. She believed that although she dieted, exercised compulsively, and struggled with weight, she was never really overweight until the dissolution of her second marriage. The mother of five, Gloria experienced weight gain and loss with each pregnancy. The largest gain, after a divorce, caused her to have an epiphany that she has lost and gained weight for or about men for too long. She continues to overeat at stressful times, but she believes she has reached a point where any weight lost now will be for her. .

Diana has gained a large amount of weight since she became a mother 25 years ago. She has attempted to lose weight with varying degrees of success, but she often gained the weight back. She seemed to take a lot of things at face value and did not spend a lot of time worrying. Her coping strategy has been to give her weight little thought, to raise her daughter, work hard, concentrate on taking care of her mother and support her church and community.

I liked and ate sugary foods early in life; this may have been the first bad habit to foreshadow my weight gain. I viewed myself as overweight long before I was heavy. Weight gain struggles began for me in late adolescence, first after the loss of my mother and then after I was sexually assaulted. I used food as a drug and comforter during stressful life events. Medication for a chronic illness exacerbated the already difficult struggle I was having with weight. I believe the weight has been a protective armor in a world where I felt vulnerable, and that the weight I have carried is a metaphor for the weight I carry in life.

Research Question One

The goal of question one was to understand how African American women described the experience of being overweight. I found that the participants had distorted perceptions about weight, dealt with judgments from others, fears of rejection by the opposite sex, and physical problems that range from minor discomfort to major illnesses.

Distorted Perceptions

Every participant had some form of distorted thinking about her body and her weight. This thinking began before many of the participants became overweight. Five of seven participants thought that they were overweight at points when they were not. This is incongruent with the research of Lovejoy (2001), who found that African American women saw themselves as a normal weight even when they are overweight. While every participant discussed points in her life where she was at a normal weight, or even underweight, it is noteworthy that this was from their current perspective of extreme obesity.

Sonya's perception of herself as overweight was fostered by childhood messages that she was overweight, while Jean's distorted thinking about her weight and body began in adolescence. Sue also believed she was overweight when a review of photos from adolescence showed that she was a normal size. Like me, Gloria experienced others' reactions to her height as an indication that she was overweight. We heard comments like, 'She's such a big girl' and 'Ooh, you're a big girl aren't you?'

Being overweight became part of participants' thinking before the actual weight appeared. Lovejoy (2001) described this as "perceptual body image." Women perceived their bodies to be much larger than they are. The result of these perceptions was the opposite of anorexia; they became more of a self-fulfilling prophecy.

Two participants did not see themselves as having weight problems when others did. Diana and Rhonda ignored comments that weight was an issue until confronted by people whose opinion they valued. Rhonda was able to hear from her best friend in college that she really needed to lose weight. Diana responded to a doctor after learning she had health issues. Rhonda, however, made strong arguments in support of African American women weighing more. She tied this to African American woman's aging process and the role they eventually played as grandmother. She described them as "big mamas," saying "whoever heard of a little big mama." She addressed a common cultural experience that is tied to the support network African American families have had through extended kin (Collins, 1993). "Big mamas" have provided social and emotional support to their children and their grandchildren and intervened in the absence of a parent (Kinnon, 1994; Gibson, 2005).

Judgments from Others

Being overweight is a stigmatizing condition that often leads to judgments from others (Crocker, Cornwell & Major, 1993). While being overweight is the result of multiple factors, people tend to blame the person who is overweight (Rodin et al., 1989; Crocker et al., 1993). All the women in this study experienced the stigma of being overweight

In addition to hearing from people whose opinion they valued, women in this study were hurt and surprised by unsolicited judgments about their weight. Rhonda, Sonya, Gloria and Diana lived with critical comments from siblings. They heard:

> Ole big Glo … you're so greedy…you look like a beached whale … men don't want a big woman.

Sonya dealt with disturbing looks from people on airplanes, unwelcome advice from colleagues:

> This is not good for you … you really are damaging your health ... You really need to do something about …

and insensitive comments from a doctor:

> '… there was so much fat around your stomach that there was no way for me to see what I was doing during the surgery, I just had to feel my way … so please don't put me in this predicament.'

While some comments came from concern, insensitive remarks left the women feeling guilty and irresponsible. They concluded that there is a pervasive belief that overweight people are irresponsible and need advice from others. Sonya summed it up nicely:

> My sense is that with the attitudes we have in this country, and I suspect that they are pronounced for African Americans, period, well those that are overweight, [are]pronounced because we are basically considered to be irresponsible as people, undisciplined as people and therefore not doing what we could do to take care of ourselves-- therefore causing the problem. I think in general fat people are blamed for their medical conditions, and African Americans, because of the other messages and stereotypes that are present in our society, we are kinda given a double whammy with this notion, which I don't think helps a person to really deal with the real issue of obesity.

Rejection by men

The dominant cultural value of thinness makes rejection of overweight women a factor that reinforces eating disorders (Sobal & Burstyn, 1998). Overweight or "thickness" in African American women has been depicted as attractive to African American men (Beauboeuf-Lafontant, 2001), but women in my study reported feeling rejected long before they reached levels of obesity. In fact, as these women began to gain weight, or "thickness," *men* rejected

them. Rejection by the opposite sex is not uncommon in anyone's life experiences, but these women tied their experiences with weight gain directly or indirectly to a rejection that made them feel unattractive. Rhonda lost weight when she overheard a boy she had an attraction to say he would not go out with her because she was fat. Gloria worked to stay thin to please her first husband, and gained weight when her second husband divorced her. Gloria believed that first her husband was atypical of African American men.

> Of all the Black men I've dated, that man was the only black man that felt like he wanted a thin woman. Other black men said 'the only person that wants a bone is a dog.'

Jean decided that in order to find some peace with herself and her body she would have to give up on men. She believed they were mostly visual creatures and she did not see herself capable of meeting their expectations or being loved the way she wanted. Diana's weight gain followed her decision to leave men out of her life and raise her daughter. She had experienced considerable pain when the father of her daughter failed to be a part of their lives. She also made sure that no one knew of her pain. I had a boyfriend who told me that he would marry me if I lost 50 pounds. The unspoken rejection was that he could not marry me without conditions. I took that to mean I was not good enough at my current weight.

Physical discomfort and health problems

The literature on weight gain is replete with information on the physical strain and health disorders associated with weight gain and obesity (Adderly-Kelly & Williams-Stephen, 2003; Banks-Wallace, 2002; Rosenberg, Palmer, Adams-Campbell & Rao, 1998; Tilghman, 2003). Similarly, women in this study experienced a range of discomforts from not being able to fit in chairs, difficulty keeping pace with others, knee pain, shortness of breath and other health issues that physicians have tied to weight gain. Rhonda, Diana, and I have high blood pressure. Sue

and Jean were recently diagnosed with high cholesterol. Diana's problems with her gallbladder lead to surgery; the problems were related to her unhealthy diet. Sonya was told her weight affected her ability to carry a pregnancy to term, and Rhonda was told the weight was causing enough problems to her bones that it would eventually kill her.

Research Question Two

The next question focused on the relationship between emotional stress and overeating in African American women. All the women used overeating to cope with stress and strain in their lives. This section will discuss both the times that women consciously used food to cope with emotional stress, and stressful times that they thought could be related to their overeating. Common themes that arose around emotional stress and overeating included the burden of their role responsibilities, and using food as comfort.

Role Responsibilities

The findings in this study are congruent with the literature on the multiple role responsibilities of African American women (Banks-Wallace, 1999; Collins, 1991; hooks, 1993). Women in this study carry a multitude of responsibilities, deny themselves while caring for others, are key support persons in their families, and have become large women.

Sue was a single parent. She felt depressed from the enormity of her role as mother to her young son. She used food to cope, and found that she had gained more weight after he was born than she did during the pregnancy.

> It was depression, cause I know after I had my son, Tyler, I weighed more two years later than I did when I was pregnant with him. Looking back I think it was depression, because I was, financially, it was hard for me because, you know, being a single parent,

not making a lot of money. My son's father, he wasn't, well he couldn't be as supportive…

Jean found that she experienced tremendous fear as she looked at the responsibilities she faced as a parent and bread winner. She took her role as mother very seriously, and when she realized her husband would not provide emotional support or carry his share of the household load, she was overwhelmed and scared.

Diana's role in the family included being a single parent to her child, but she was also the oldest daughter and the adult child that remained at home with her aging mother. Her role as caretaker included her own child, her niece and now her mother. She was also the sibling that everyone went to for help, be it financial or emotional. Diana's ability to be responsible and care for others extended to her community, the church and job. She was often asked to work late or to assist with some project or task. She found that the level of responsibility she took for others robbed her of time for herself. She was not aware of this, however, until she had gained considerable weight; she realized that she seldom stopped to think about what she was eating or engage in physical activity.

Rhonda took her role as mother to her four children very seriously. At one point she became "mom," chief of nurturing children and maintaining the home, and with that role she also became an excellent cook. She stayed at home during their earlier years while her husband provided financial support. When she returned to the workforce, she found herself with dual role responsibilities. Her family expected this of her and her children particularly enjoyed her cooking. She enjoyed the science of cooking and making things taste pleasurable. Outside the home, she works as a medical social worker. The nature of her work is stressful, and her job roles include caretaker, active listener to others' troubles, and problem solver. Her dual

responsibilities left little time for herself, and she also used food as a stress reliever from both home and work responsibilities.

Sonya learned in childhood how to care for others when she helped her mother take care of her younger siblings. She took that early experience and made it a life-long role. Sonya's relationship with her immediate and extended family is enmeshment. She is the primary caretaker for her ill and aging parents; she is the person her siblings come to for emotional and financial support, and she cares for her husband, whose obesity has disabled him. She is also director of a program whose goal is to protect children. While Sonya manages her multiple roles, she has grown aware of how her experiences have affected her weight. These insights have helped her to begin to set boundaries and care for herself. Her weight has stabilized.

Being a single parent to five children and a support to her children as they raise 11 grandchildren makes it hard for Gloria to carve out a role other than parent. Nonetheless, she has entered a profession where counseling and caring for others are a part of her workload. She finds it hard to let go of the cases she sees, and she works with physical and sexual abuse victims. Because her career came late in life, Gloria sees the challenges as a part of her effort to care for herself. She finally has the degrees and professional life she wanted.

I began the role of caretaker when my mother died and I saw my stepfather abusing alcohol and drugs. I began raising my 4-year old sister when I was 19 and took full responsibility for her when I was 23. This cycle of caretaking has taken many turns, and it manifests itself in several ways. I have difficulty saying no to others. I tend to take the lead role in most of my undertakings. My thinking was similar to Sonya and Diana, "my family and/or community need me, how can I say no?"

The literature suggested that the image of the *Strong Black Woman* is similar to the *Mammy* image and both images are of women that are self-sacrificing, often happily serving others and a provider of strength and support to the family (Beauboeuf-Lafontant, 2001; Collins, 1991; hooks, 1993). These images are also repeatedly tied to large Black women. Consciously or not, the problem of obesity in African American women is a natural link to these images.

Food as Comfort

Eating to satisfy something other than hunger was a common experience of the women. I have often said that food is my drug of choice; I use food to ease emotional pain. Sue views food as a friend through lonely periods. She personified it by saying food would never leave her. Gloria tied one of her largest weight gains to the break up of her marriage, when she ate nonstop until she fell asleep. Jean uses food to deal with loneliness. She likes to eat out, because even when she is alone, she feels better in the company of others in the restaurant. Sonya ties specific foods to her feelings. Her sadness is calmed by chocolate, and low energy is met with any sweet. The participants' physical and emotional relationships with food resonate with current research. One study done on rats, found that the effects of sugar addiction, withdrawal and relapse resemble those of drug addiction (Wideman, Nazdam, & Murphy, 2005). Wansink, Cheney, & Chan (2003) found that women's choice of comfort foods tended towards snack foods such as chocolate and ice cream. Dallman, Pecoraro, & la Fleur (2005) found that comfort foods are a form of self-medication that actually helps reduce feelings of chronic stress. But scholars have not ignored the symbolic dimensions of food addiction. Locher, Yoels, Maurer, & Van Ellis (2005) used symbolic interactionist and structrualist approaches to study the social construction of what they called "food objects" as comfort foods; they suggested four categories of comfort foods: nostalgic foods, indulgence foods, convenience foods, and physical comfort foods.

In particular, ice cream was a common comfort food for both physiological and emotional/cultural reasons. Rhonda learned to use it during challenging times at work. It was Sonya's favorite indulgence when she was down, and Moose Track Ice cream became Sue's "Friday night date." I laughed to myself when I heard this because I knew that my end-of the-week reward was often Ben and Jerry's New York Super Fudge Chunk ice cream.

Jean also believed that food is a kind of comfort. She thought that overeaters have foods that are their nemeses. These are foods that comfort you initially, but eventually cause you grief. In the past, hers included cookies, pies, and cakes.

Research Question Three

The final question sought to understand what life experiences impacted the outcome of obesity. It seems that being born an African American woman predestined most of the women to have some struggle with self-image that was exacerbated by being overweight. Almost unanimously, becoming pregnant and parenting seemed to be tied to gaining weight and obesity. Subsumed under parenting was being a single parent. Other significant life experiences included the loss of a parent, and physical or sexual abuse.

Five of the seven women were born into large families of origin. Whether this is relevant to the issue of weight was not clear. Just one participant, Sue, was an only child. I identified with the position of only child, but my position in my family of origin is a little different. While I was an only child until I was 15, I was the oldest sibling thereafter. Furthermore, my relationship with my mother was very sibling like, and my relationship with my sister was very parental. I felt sometimes like my grandmother's tenth child.

A discussion of the life experiences that impacted body image, overeating, weight gain and consequently the outcome of obesity, follows.

Parenting

Parenting for African American women is tied to a socio-cultural and historical belief that being a mother extends beyond the immediate family and includes "fictive kin" as well as biological children; African American motherhood is viewed as an institution that includes social activism for the community (Collins 1993). Parenting then is a source of pride that has been compromised by societal change including high divorce rates, an increase in single parents, and a decline in family support (McAdoo, 1998; Tucker & Mitchell-Kernan, 1995).

All the women in this study were parents. All were biological mothers. Sonya had a son by birth and an adopted daughter, and I have a son by birth and a foster daughter. Sue, Rhonda, Gloria and Diana noticed that weight gain struggles began after they had their children. Rhonda found that her weight increased after having four children and staying at home to care for them. Gloria managed to lose weight after every pregnancy, but she believed she gained a significant amount with her pregnancies.

The responsibilities of being a parent and for some, a single parent, were a part of life experience that contributed to weight gain in some of the women. Jean kept her weight gain at bay for some years through extreme diet and exercise, but the responsibility of being a single parent led her to overeat, and the habit of overeating led to obesity. Sue found that being a single parent meant that she had to be mother and father to her son. Her parenting was compounded by the loss of her son's father through death. While they were not married, he had been a support to her and an involved father before his death. She reached a point of extreme obesity as she ignored her health, worried over finances and tried to care for a son that was hyperactive. Diana remembers clearly that her weight gain began when she became a mother. She dedicated her life after becoming a good mother to her daughter. She showed the most emotion about the lack of

support that she received from her daughter's father. He died when their daughter was in college. Diana resented having to deal with the affect his life and death had on their child.

Loss of Significant Others

Parental loss through death or divorce has been linked to eating disorders and body dissatisfaction (Beam, Sevrvaty-Seib & Mathews, 2004). Severe illness of a parent has been recognized as a form of loss that can affect family functioning and child-wellbeing, including depression as an indicator of psychological distress (Pedersen & Revenson, 2005). Six of the seven participants experienced a form of parental loss through death, divorce or illness before adulthood.

Diana, Jean, Sue, and I experienced the deaths of our parents before we entered adulthood. I remembered gaining weight within the same month after my mother's death. Diana did not tie the loss of her father to her eating or weight gain. She did, however, gain weight when she lost the support of her child's father. Other participants noted that the loss made them feel more vulnerable, and food was at times a way of coping. Jean thought the loss of her mother was the beginning of a stressful life that ultimately lead to her using food as a coping tool, just as the brother who cared for her used alcohol.

Sue's losses began early in life when her birth mother left her on the doorstep of someone's home. She believes this had an effect on her self esteem. In early adolescence both her adopted parents died. Recently the father of her son died. The combination of these losses has made her feel vulnerable and alone. Food has been her reliable friend.

Gloria did not lose her father to death, but she remembers the day he left with much sadness. He was not a part of her life again until she became an adult, and in some ways she sees

his leaving as a death. Similarly, Sonya's father became very ill when she was a child, and her mother had to garner her support in caring for the children and handling the finances.

> I was doing something to really relieve some of the pressure off of my mother because I saw at that point my father was ill and she had to take on the field work the farm. There were eight of us there in the house. She would come and give me money and ask me to hold it for her, and at times she would say don't let me come back and get this. Now as I look back on this, I was 11 and 12 years old so to have that kind of responsibility that I needed to be clever enough to come up with ways for mom not to come back and get this money … it ended up being a burden. I look back on my childhood, I felt like a person who … I knew I wasn't, a grownup, but I just felt this sense of responsibility that weighed so heavily.

Like Sonya, I took responsibility for my younger sibling when my mother died. I received advice from adults that she was not my responsibility and I was giving up too much to raise her. I, like Sonya thought that I was the only one available do this, and I was responsible. Researchers have connected parental loss to change in role responsibilities and identity development (Cait, 2005; Pedersen & Revenson, 2005). This can result in the child taking the care giver role and they become "parentified children" (Byng-Hall, 2002). The parentified child can have the role of parent to one or more family members, and it can move beyond role reversal. Sonya and I took the role of parents to our siblings, and Diana became a parent to her niece. The caregiver role extended into adulthood; Diana now cares for her mom, Sonya is responsible for her mother and father, and I took a grandmother role with my nieces and nephews.

Parental loss took various forms for the participants. It was a life-changing experience that left them feeling burdened to varying degrees.

Physical and Sexual Abuse

Gloria, Diana and I were sexually assaulted and molested. The women did not share that they had tied this to the outcome of obesity. In fact, Diana tried to 'forget about it' and Gloria found it difficult to discuss during the interview. Diana's strong feelings that "sex is dirty" and her denunciation of sex could be easily tied to her experience of molestation. Sonya told me that she was "hit on" (sexualized, strong flirtations) by men, and at times wondered if her weight would keep them away.

Thompson (1992) reported that sexual abuse was a factor in overeating for African American women. Similarly, Gay (2002) found that African American women are overly sexualized. Previous research suggested that African American women are less likely to cope with painful experiences, like physical and sexual abuse, by acknowledging the pain and trauma (Beauboeuf-Lafontant, 2001; Root, 1990; Thompson, 1992). Overeating, that leads to obesity becomes a mechanism for numbing the pain.

Jean and Gloria experienced physical violence in their marriages. Gloria said she thought abusive men went to school to learn how to dehumanize women. Her efforts to stay thin were compounded by a belief her husband perpetuated. The belief was that she would never be appealing after having a child out of wedlock. Interestingly Gloria's professional work is with children of abuse and perpetrators of violence and sexual abuse.

CHAPTER VII

IMPLICATIONS FOR RESEARCH AND PRACTICE

A recent interview in the New York Times (Dreifus, 2006) with heart specialist Dr. Herman A Taylor Jr. focused on the high mortality rates for African Americans related to heart disease. Dr. Taylor is the director of one of the largest epidemiological studies on the link between cardiovascular disease and race. He is collecting data in a southeastern state, Mississippi, and has connected his early findings to high levels of obesity in African American women (Dreifus, 2006). He said:

> African American women lead the way in obesity nationally, and our numbers here are significantly higher than that. (Dreifus 2006, para. 15)

The exciting piece of this study is that researchers in the medical field are looking at factors beyond the physical. Similar to Engle's (1992) recommendation for a biopsychosocial model for disease, they are exploring information on social support, anger, optimism, access to healthy lifestyle, and economic depression.

This recent information is compatible with the implications for future research and practice I discuss in this chapter.

Future Research

This study focused on the emotional linkages to obesity and overeating in African American women, an area of the obesity epidemic that is seldom researched. Weight, race and gender related experiences are sensitive topics individually. Researchers must then take special care when they are looked at together. Generally, more qualitative studies on emotional and

psychological factors that impact weight in African American women and women of color are needed. Specifically:

1. Women in this study shared similar historical experiences related to culture and race. All but one of the women was born in the South, and these women shared the life experience of integration in the southern school system. Cultural standards of beauty were more clearly delineated. A study on the impact of integration on standards of beauty for African American women is recommended.
2. All of the women in this study were from the southeastern region of the U.S.; a study on overweight African American women from another region could be a useful comparison.
3. This is a need to explore the relationship between weight gain and overeating on the birth order or position a child holds in the African American family. Women in this study that were from large families were in different birth orders, but further exploration showed that some of them functioned as the more responsible child, a behavior expected of the oldest child.
4. The literature on weight in African American women consistently suggested that being overweight was not viewed the same by African American women and men. Women in this study were not accepted by family members and some of the men in their lives when they gained weight. They received messages before gaining weight that being heavier was not acceptable. A study that explores the incongruence in cultural messages and behaviors is indicated.
5. While women in this study all wanted to lose the weight, few were able to make consistent changes. One implication is that there is a level of comfort in that which is

familiar. Based on this, an area of further research would be to look at the psychological and social impact of weight loss in previously obese African American women.

6. Most of the women in this study were middle class, although this was not a criterion for participation. Future studies on this topic will need to explore socio-economic class differences.

Practice Implications

A number of practice implications were indicated as a result of this study. They are listed below:

1. Therapeutic diagnosis and interventions should be focused on obesity as a symptom of disordered eating, if not a full fledged eating disorder. Obesity is established as a life threatening illness that has consequences for both the physical and psychological wellbeing of the individual. Intervention and treatment should focus on both.
2. Medical family therapists trained to look at the emotional components of a medical disorder should be a part of an interdisciplinary approach to addressing obesity in African American women. The impact on family dynamics should be assessed.
3. Women in this study received strong messages about their weight and body from family members. Family therapy should focus on family-of-origin issues related to early messages about body size and weight.
4. Treatment options for the emotional and mental health aspects of obesity are limited because insurance providers only respond to obesity as a physical health problem. Policies should be developed that effect treatment for obesity as a psycho-social, mental health or some non-physical disorder. This would expand treatment options and allow for holistic approaches to care.

5. Treatment options may need to include educational programs that address the cultural and historical factors that impact weight in women of color, in addition to the mechanics of weight loss. Community groups and agencies could sponsor such programs.
6. Prevention of obesity in children is a growing concern. Early intervention programs that provide psycho-social education to young African American girls and their families about body, weight and self esteem could reverse the current trend towards obesity.

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APPENDICES

APPENDIX A
IRB Approval Forms
Letter and Application

Date: Fri, 03 Mar 2006 11:35:53 -0500
From: Kirsten Walters <kwalters@uga.edu>
Subject: re: approval period extension
To: kulkosky@uga.edu

PROJECT NUMBER: 2003-10598-2
TITLE OF STUDY: An Exploration of Emotional Linkages to Obesity and Overeating in African American Women
PRINCIPAL INVESTIGATOR: Ms. Terri Earl-Kulkosky

Original Start Date: 2/21/2003
5 year End Date: 2/20/2008

Terri,

This email concerns the renewal request for the project referenced above. You no longer need to submit annual renewal applications for this project since the review category it falls under does not require annual IRB continuing review (see Policy Change box below). However, if you need to amend the existing protocol, you will need to send a Researcher Request Form to our office (See Amendment Procedures box below).

Because we are no longer sending out reminders, we are requesting that you notify the Human Subjects Office if your study is completed or terminated so that we can close your project file.

Please feel free to contact us if you have any questions.

Kind regards,

Kirsten

Kirsten Walters
IRB Coordinator
University of Georgia
Institutional Review Board
Human Subjects Office
606a Boyd GSRC
Athens, GA 30602-7411
p: 706-542-3199
f: 706-542-3360
e: kwalters@uga.edu
UGA IRB homepage: www.ovpr.uga.edu/hso/

The University of Georgia
Office of the Vice President for Research
Institutional Review Board/Human Subjects Office
606A Graduate Studies Research Center **Athens, Georgia 30602-7411**
(706) 542-3199

APPLICATION FOR APPROVAL OF RESEARCH
WITH HUMAN RESEARCH PARTICIPANT

(*Check One*) **Dr.** ☐ **Mr.** ☐ **Ms.** ☒	(*Check One*) **Dr.** ☐ **Mr.** ☐ **Ms.** ☐
(*Check One*) **Faculty** ☐ **Undergraduate** ☐ **Graduate** ☒	(*Check One*) **Faculty** ☐ **Undergraduate** ☐ **Graduate** ☐
Terri Earl-Kulkosky / 255-98-6132	
Principal Researcher / **Soc. Sec. No.**	**Co-researcher** / **Soc. Sec. No.**
Child And Family Development 123 Dawson Hall Athens, GA 30602	
UGA Department AND UGA Mailing Address (Include department even if living off campus or out of town.)	**UGA Department AND UGA Mailing Address**
Mailing Address (if you prefer not to receive mail in dept.)	**8:00 a.m. - 5:00 p.m. Phone Number (s)**
(706) 542-5578; kulkosky@arches.uga.edu	
8:00 a.m. - 5:00 p.m. Phone Number (s) (If you prefer to be contacted by email please include address.)	
****Signature of Principal Researcher**	**Signature(s) of Co-researcher(s)**

UGA Faculty Advisor:	Dr Patricia Bell-Scott	Child And Family Development	Dawson Hall	706-542-4899
	Name	**Dept.**	**Building**	**Phone No.**

UGA Advisor☐
****Signature:** _____ **Soc. Sec. No.:** _____ **Date:** _____

****Your Signature indicates that you have read the ☐Excerpts☐ document and that you accept responsibility for the research described in this application. It further attests that you are fully aware of all the procedures to be followed, will monitor the research, and will notify the IRB of any significant PROBLEMS or CHANGES.**

If funding

is involved:

Sponsored Programs Proposal Number	**Name of Funding Agency**	**Proposal Deadline**

Please list any funding or any possibility of funding. Failure to do so may delay awards.

TITLE OF RESEARCH: An Exploration of Emotional Linkages to Obesity and Overeating in African American Women

NOTE: THE PERSONNEL IN THE HUMAN SUBJECTS OFFICE ARE NOT RESPONSIBLE FOR MEETING RESEARCHER DEADLINES AND CANNOT PREDICT OR GUARANTEE APPROVAL DATES. SUBMIT AS EARLY AS POSSIBLE TO MEET YOUR DEADLINES.

Date You Would Like to Begin Research: 2/24/2003
(at least 4-6 weeks from date of submission to IRB)

Date You Expect to Complete Collecting Data: 1/30/2004
(Period of approval cannot extend beyond one year; if more time is needed, study must be renewed before end of approval period.)

APPLICATION FOR APPROVAL OF RESEARCH WITH HUMAN RESEARCH PARTICIPANTS

1. **PROBLEM ABSTRACT: State rationale and research question or hypothesis (why is this study important and what do you expect to learn?).**
   Current findings indicate that more than half of African American women are overweight with many falling into the obese and morbidly obese categories (Freedman, 2002; Dortch, 1997). Physical factors leading to and maintaining obesity have been studied (Kumanyika, 1997), and diseases associated with obesity are well documented. (Weinsier, 2002; Horsham, 1999). A growing body of literature focuses on the connection between the mind and body as it relates to health and disease (Northrup, 2001; Hay, 1998; Sarno, 1991). Research is limited however on the linkages between mental /emotional factors associated with obesity in African American women. This study provides an opportunity to examine the relationship between emotional stress, overeating and obesity. A study of this nature can lead to a more holistic approach to what is a life threatening problem in a large percentage of African American women.

2. **DESIGN: Identify your research design and specific factors or variables, conditions or groups in your study, and any control conditions. Indicate the number of research participants assigned to each condition or group, and describe plans for data analysis**.
   .Focus groups and individual interviews will be held with middle age African American women who are clinically obese. The initial phase of the research will involve a pilot study of of 3-6 women between the ages of 40-60. They will be interviewed in a focus group and/or in individual interviews. Interviews will last one to one and one half hours. The interviews for this phase of the project will be completed by May 30, 2003. The second phase individual interviews will be held with 8-10 women for a more in-depth analysis of issues and themes that were highlighted in phase one interviews. Each interview will last approximately one hour. The study will be completed by January 30, 2004. Data will be transcribed and recurring themes analzyed.

3. **RESEARCH PARTICIPANTS:**
   a. **List approximate number of participants 15, targeted age group 40-60 (specified in years) and targeted gender Female;**
      Approximately 15 African American women will be interviewed that are between 40-60 years of age.

   b. **Method of selection/recruitment of research participants -- specify each source of participants and researcher(s) working relationship, if any, with the participants.**
      NOTE: If you are recruiting research subjects/participants from an institution(s) other than the UGA, include authorization letter from the appropriate official(s) of the institution(s) with your application.
      Participants will be recruited through exisiting African American community groups and individual referral networks. Professional colleagues will be made aware of the recruitment criteria and asked to be a part of the referral network. In addition to the aforementioned criteria, participants will be selected based on their Body Mass Index (BMI), determined by height and weight. Recent studies in The Journal of the American Medical Association note that a BMI of 30 or greater is considered clinically obese. (Mokdad, 2003)

c. **Describe any incentives, follow-ups or compensation to be used with individual participants. This includes payment, gifts, extra credit, etc.** **NOTE**: UGA employees working half-time or more are not allowed to receive financial compensation in return for their participation. Extra credit must not be offered unless there are equal non-research participation options available to students.

I will facilitate a psycho-educational group focused on the emotional aspects of obesity and overeating. I am a clinical social worker and marriage and family therapist with 20 years experience in the psycho- therapy field. I am also a tenured assistant professor of Social Work at Fort Valley State University. These combined skills will be used to develop a psych- educational group. Participants in the focus groups and individual interviews will be invited to participate. This is entirely voluntary as participants may or may not be seeking help with obesity or overeating.

4. **PROCEDURES: State in chronological order what research participant is expected to do and what the researcher will be doing during the interaction.**

Participants will provide demographic information to the investigator on age, race, height and weight. The researcher will use the information to determine the Body Mass Index (BMI) of each of the participants. Participants will respond to a series of open-ended questions posed by the interviewer during a one to one and a half hour session.

Descriptions of the demographics and interview guide, listing the general questions to be asked of participants, are attached to this application.

5. **MATERIALS: List in sequence all questionnaires and/or tasks given to the research participants. Attach a labeled copy of all written instruments to each copy of the application. Each attachment should be identifiable from your description given here. If an interview will be conducted you must include an interview script or set of questions.**

1. Consent form. 2. Interview guide.

Consent form to be used with all participants is attached.

A copy of the interview guide to be used in focus group and individual interviews with participants is attached.

6. **RISK: The IRB seeks information about risks that a research participant may encounter as a result of data collection and any that may arise in the future as a direct result of the research. In both cases, carefully describe any such risks and how you plan to minimize them. The latter must include the availability and limits of treatment for sustained physical or emotional injuries. (NOTE**: any incident directly related to research participation causing significant discomfort, stress or harm should be reported to the IRB immediately**):**

a. **CURRENT RISK: Describe any psychological, social, legal, economic or physical discomfort, stress or harm that might occur to the participants as a result of their research participation. How will these be held to the absolute minimum?**

Some psychological discomfort is expected when discussing personal matters. I will conduct each interview, and I will make use of my expertise as a trained clinical social worker and marriage and family therapist to minimize the level of discomfort while exploring emotional issues.

b. **FUTURE RISK: How are all research participants protected from potentially harmful future use of the data collected in this project? Specify whether the results of participation will be anonymous or confidential (it cannot be both).** By anonymous, the IRB means that the researcher does not know the results of the subject's participation. If there is any way for the researcher to identify data as related to a specific individual then only confidentiality may be promised. Confidential means the researcher may be able to identify a participant's results but will not reveal the participant's identity to anyone else. Person-to person interviews are never anonymous**. Describe your plans to maintain**

confidentiality, and state who will have access to the data and in what role. Be sure to provide specific measures planned to remove any direct identifiers, as well as data storage. You must justify retention of identifying information on any data or forms. DO NOT ANSWER THIS QUESTION WITH "NOT APPLICABLE".

No future risks to participants are foreseen. Referral sources will be made available to local therapists in case participants experience distress related to the subject matter. Participation will be confidential. Individual participants will not be identified by name in any written transcriptions or reports of focus group interviews, and details that could potentially identify individual participants will not be included in any reports. Audio and video tapes of the interviews will be accessible only to the researcher, the class professor, doctoral advisory committee members and transcriptionists. Data will be stored in a locked file only accessible to the researcher. Audio and video tapes will be erased once a complete and accurate transcription of their contents has been made. All tapes will be erased no later than January 2005.

7. **BENEFIT: State the benefits the participants will gain from the study and the benefits that humankind will receive. In some cases, the participants will receive credit toward some course requirement. Most, hopefully, will derive educational benefits, especially if they are students. You must also indicate how your project will benefit humankind, e.g., advance our knowledge of some phenomenon or help solve a practical problem. As in the RISK section, you must acknowledge the benefits of your study for the IRB to judge whether benefit exceeds risk to the participant. You MUST list benefits in order for your study to be approved. Potential benefits of the research must outweigh any risk associated with research participation.**

   a. **Identify any potential beneficial effects on the participants that might result from the research;**

   African American women will have an opportunity to share their ideas and concerns about being overweight with a particular emphasis on emotional stressors. Focus group members will have an opportunity to share their thoughts with similar women. The experience of expressing feelings and experiences with others has been known to provide a form of cartharsis. Ultimately, suggestions may be made that will result in improved or enhanced programs that could benefit this population.

   b. **You must identify any potential benefits that humankind in general will gain from this research.**

   A better understanding of the issues and challenges faced by African American women regarding the emotional factors that influence the weight that they carry can lead to more effective services for this population, improved mental/emotional health. It may offer new directions for future research.

8. **CONSENT FORM: How will legally effective informed consent be obtained from all research participants and, when applicable, from parent(s) or guardian(s)? If DECEPTION is used in your study, describe how participants will be deceived, why it is necessary, and how you will debrief the participants. Provide the IRB with a copy of a written debriefing. Also include in the consent form a statement such as "In order to make this study a valid one, some information about my participation will be withheld until completion of the study." In certain instances, such as mail-out surveys, a cover letter may be used, but it should include at least the information shown in the consent form. This is known as implied consent format. If written consent will not be obtained, a full explanation of the reasons must be submitted for approval, including assurance that risk to the participant will be minimal. Be sure to answer this question and supply the appropriate consent document. Refer to Section VIII of the IRB Guidelines for additional information and the required consent format. A checklist is available to help you ensure that you have included all the necessary components.**

   Researchers will obtain written consent from all participants before the focus groups or individual interviews begin. Consent form attached.

9. **<u>VULNERABLE PARTICIPANTS</u> including MINORS: If minors or other vulnerable participants are involved, outline procedures to obtain their agreement (assent) to participate, in addition to the consent of parent(s) or guardian(s). Describe in any other special procedures that will be used to minimize risk to these vulnerable subjects. When you use MINORS or other VULNERABLE POPULATIONS, informed consent must be obtained from parent(s) or guardian(s), or a clear justification must be provided so that the IRB can determine if they will approve to waive the requirement. An understandable explanation of your procedures should also be presented to minors and other vulnerable participants, and they should be given an opportunity to volunteer their participation. This is called "assent" for people who cannot give "legally effective informed consent." An assent script or form should be attached to the application submitted to the IRB.**
Vulnerable participants will not be included in this study.

10. **ILLEGAL ACTIVITIES: Participants must be assured their data is either anonymous or will remain confidential. If the data will be confidential you must inform research participants that you may not be able to guarantee confidentiality if disclosure should be required by law (see Number 5 in the consent format in Section VIII of the IRB Guidelines). Some ILLEGAL ACTIVITIES must be reported, (e.g., child abuse). When anonymous questionnaires are used but written informed consent is necessary, consent forms may be signed and returned separately. This procedure avoids any possibility of linking names to the data. Does the data to be collected relate to illegal activities? Yes☐ No☒, If yes, explain.**

11. **Check all of the following that apply to this application:**

This application is being submitted for a class assignment. ☒

This application is being submitted to conduct a pilot study. ☒

The protocol described in this application project involves the use of audio-taping. ☒
The protocol described in this application project involves the use of video-taping☒

This application is being submitted for Thesis Research, exit exam research or an applied project. ☐

This application is being submitted for Dissertation Research ☒

The activity described in this application involves another institution(s). ☐
(EXAMPLES: school, university, hospital, prison, agency)

Recruitment flyers or advertisements will be utilized. ☐
Attach for review.

APPENDIX B

Emotional Linkages to Obesity and Overeating in African American Women
Participant Consent Form

My name is _____, and I want to take part in the research study titled "Emotional Linkages to Obesity and Overeating in African American Women". Terri Earl-Kulkosky, Department of Child and Family Development at the University of Georgia, (478-825-6636) is the researcher leading this project. The supervising faculty member is Dr. Patricia Bell-Scott (706-542-4899).

I understand it is my choice to take part in this study. I can refuse to answer any question at any time. I can also decide not to take part before, during or after the interview takes place. If I do decide not to take part, there will be no penalty. And anything that is identifiable as mine will be returned to me, removed from the research records, or destroyed.

The following points have been explained to me:

- If I volunteer to participate in this study I will be asked to answer questions about my thoughts and feelings about my weight, and experiences in my life that have been affected by my weight and my eating. The researcher in this study may call me to clarify my information after the initial interview.
- There are no risks to me for taking part. Although the interview will be recorded through audio and/or video and transcribed, and my real identity will not be known. In the final results, I will be identified by a fake name made up by Mrs. Kulkosky. These tapes will be destroyed within one year of the interview taking place. Written records of this study will be maintained for future educational research, however, only the fake names will be used. Results will not be released in any way that makes known my true identity, without me saying that it is okay in advance, unless required by law.
- Terri Kulkosky will answer any further questions about the research at any time I ask. If I have more questions, I can contact Dr. Bell-Scott at the phone number listed above.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____ _____

Signature of Participant Date Signature of Researcher Date

Research at the University of Georgia that involves human participants is carried under the oversight of the Institutional Review Board. Additional questions or problems regarding your rights as a research participant should be addressed to the IRB chairperson in the Human Subjects Office at the University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411. Telephone: (706) 542-3199; E-Mail Address: IRB@uga.edu

APPENDIX C

Participant Demographics Data Sheet

Participant	Years Over-weight	Age	Height	Weight	BMI	Relation-ship Status	Number Of Children	Job Title

APPENDIX D

Interview Guide

1. Would you walk me through your experience(s) of gaining weight?
   How old were you the first time you remember gaining weight?

2. Tell me about your responses to weight gain.

3. Can you share with me some of the feelings you've had around eating and food?

4. Would you discuss any physical discomforts or health crises
   How do you see that related to the weight?

5. How do you feel about yourself and your body?

6. How do you see yourself as a human being?

7. How do you think your view of your body and weight gain may have been influenced by your sexual experiences?

8. Would you share any thoughts or feelings you have about how this experience relates to being an African American woman?

APPENDIX E

Resource article for non-participants

Fat is a black women's issue

Essence, Oct, 1989 by Retha Powers

FAT IS A BLACK WOMEN'S ISSUE

A YOUNG SISTER TAKES A PAINFULLY HONEST LOOK AT HER EATING PROBLEM--AND OURS

My nickname in elementary school was Fat Alberta--Fat Albert's sister, fictionalized by a group of rowdy 10-year-old boys. The obviously unwanted nickname traveled with me to the ends of my largely white neighborhood. This identity tormented me so much that I tried to run away when I was 9.

One afternoon, after being incessantly teased about my prepubescent potbelly, I went home and packed a plastic bag full of some of my favorite clothing, a doll that was my namesake, a pound of grapes and other assorted foods I meant to survive on until I returned home, thin. Before I could execute my plan, my mother discovered me on the staircase in our apartment building and told me to come in for dinner.

Soon after that my mother introduced me to my first diet, "The Woman Doctor's Diet for Women." I followed the strict menus of baked chicken without skin, skim milk and baked everything else for three months and lost 25 pounds. Throughout the entire restrictive period I felt deprived and unsatisfied. Looking back at photographs today I see that, although I am big-boned, I was an average size. Even my relatives, who after the diet stopped pressuring me to lose weight, agreed. But all of the girls who were considered pretty were ultra thin and white, and I was still teased for being "ugly." Although now I realize that the ugliness my peers saw had more to do with the darkness of my skin, I reasoned then that I hadn't lost enough weight.

So at 12, I went on my first crash diet. I could consume no more than 800 calories a day; the menu was the same daily.

Breakfast: one scrambled egg, one slice of toast (no butter).

Lunch: iceberg lettuce and a tomato, one glass of unsweetened tea.

Dinner: two ounces of baked skinless chicken, iceburg lettuce and a tomato.

Needless to say there were no between-meal snacks. But once again I followed the meal plans religiously, despite hunger pains that made me irritable and lethargy that forced me to go to bed early. At the end of ten-day period I had lost more than ten pounds, but I was angry. I was angry that I could not eat any of my brother's birthday cake, could not eat the same food my family ate at mealtime, could not eat popcorn when I went to the movies with my friends. The night my diet ended I made up for what I had missed. I furiously shoved everything sweet, spicy or crunchy into my mouth. I poured bowl after bowl of cereal and ate more cookies than I knew were permissible. Much later I went to sleep feeling pains in my stomach, but I wasn't angry anymore.

The next morning my parents were appalled by the empty cereal boxes and the pile of Tupperware containers in the sink. I lied and said I knew nothing about them. I felt guilty, so I resumed my diet, but the guilt wasn't enough to keep me from bingeing three days later on a Saturday, a day that soon became my binge day.

In this way I dieted during the week and devoured excessive amounts of food on weekends. By the end of the school year I had ballooned back up to my original weight plus ten pounds. Alarmed, I began "The Model's Ten Day Diet," and the syndrome continued. I followed each ten-day crash diet by a binge that was the result of the anger I was feeling about total deprivation. But once I introduced diet pills into the routine, I lost 40 pounds on Diet 7-Up, lettuce and popcorn.

Afterward, no one dared to call me Fat Alberta, and my relatives extolled me for my weight loss and referred to me as a "real teenager," as though prior to the weight loss I was insignificant. One aunt sent me a letter in which she wrote, "Inside every fat girl there is a thin girl dying to get out!" and drew a picture illustrating a "fat" me surrounding a "thin" me. The fat me was frowning, the thin me was of course--smiling. But in the way of families, the same relatives who pressured me to lose weight also warned me about getting "too thin" and encouraged me to pig out at family gatherings.

On the other hand, each time I opened the refrigerator at home I was met with a discouraging remark or a knowing glance even when I insisted I was hungry, so at the dinner table I tried to compensate for the hunger I had felt earlier. Eventually I became so angry at my parents'

watchful eyes and halting slaps on my hand when I reached for more that I stopped eating in front of them. My mother pleaded with me to return to meals, but it was too late. By then I felt that eating was a dirty, sinful act that I wanted to share with no one. When one of my parents did see me eating I would start, and, as if I'd been caught doing something wrong, I'd try to gulp down the morsels whole. When food was missing my parents confronted me, but I denied everything and became hostile and defensive in the manner characteristic of an addict--the addict I was. I hoarded food and went out less and less. And when I did go (usually to buy more food) I would try to hide my obesity by wearing oversize clothing. I believed I was creating a formless shield that prevented anyone from knowing where I began and ended. During the summer I allowed denim jeans to stick to my legs instead of wearing shorts, and I wore long-sleeve shirts to hide the flabbiness of my arms.

In the meantime, I discovered a new method of weight loss while reading a book about a bulimic dancer that was circulating among the girls in my school. I began by placing my finger down my throat and gagging in order to vomit the food I'd just eaten. The first few times were difficult, but it became increasingly easier. I soon became so accustomed to the routine that my approaching finger would cause me to retch. I lost weight by this method faster than I ever had before, but then I read in a fashion magazine that the acids in vomit could eat away at my teeth.

Yet again I gained weight, followed by a summer of bingeing, purging and semi-starvation--this time by way of liquid diets and laxatives. These seemed to be the perfect solution--until school started, and the method proved impractical. Consequently, at 17, I was five feet six and weighed 185 pounds. I tried to diet again, but I could no longer restrict my eating, nor did I want to accept the consequences of eating too much.

I went to see a high-school counselor and told her about my eating disorder, which had no specific name because it adapted to my need to lose weight. I felt out of control. Her response to my confession was, "You don't have to worry about feeling attractive or sexy because Black women aren't seen as sex objects, but as women. So really, you're lucky because you can go beyond the stereotype of woman as sex object; you just have to worry about being yourself."

"How can you say that after I just told you I feel inadequate?" I asked.

She told me, "I base my statements on studies I've read over the years, and as far as I know things are still the same, unless there are new studies. Also, fat is more acceptable in the Black community--that's another reason you don't have to worry about it." Then she asked me if I wanted to be a junior counselor, because I was "so stable and could be of help to students with more serious problems."

This was a common occurrence. I was constantly perceived as a maternal Black woman by my peers and teachers. I think some people actually visualized themselves clinging to me with their head on my bosom. And why not? The image of the big, strong, nurturing Black woman has existed in print and visual media for years, most prevalently in film. Hattie McDaniel won an Oscar for her portrayal of this image. Unfortunately, this problem-solver and eternal-sustainer persona becomes the life work of many women.

While I consider my experience as an overweight woman in this society quite different from that of white women, I recognize that the influences on us are the same. Because I attended predominantly white schools, I was exposed to many fashion magazines that featured sinewy models--most of whom are Aryan-like--clad in bathing suits or narrow dresses. These magazines carried most of the diets that I followed during the get-thin-for-summer season. The same magazines also ran stories that said, "You're fine the way you are" on one page, and "Let's face it, looks count" on the next. Conflicting messages of this sort cause all of us as women to doubt our worth and to measure our looks against those of fashion models.

Accordingly, my relationships with men were limited and unfulfilling. I'd usually follow a failure with a week of fasting because I blamed it on my fat. I never fully believed that any male's interest in me was genuine, and I would constantly rest their loyalty by trying to goad them into agreeing when I referred to myself as fat. When my paranoid behavior caused some relationships to fail and prevented others from beginning, I told myself that I should not be surprised, that no one wants a fat girl.

APPENDIX F

REFERRAL LIST

The following therapists or/treatment programs are local to areas from which participants will be recruited. They are referral sources because they are sensitive to cultural issues of African American women, and/or have some training/experience with disordered eating.

In Georgia:

ATHENS AREA

MCPHAUL FAMILY THERAPY CLINIC
Provides individual, couples, and family therapy.
Services provided on a sliding fee scale.
706-542-8810

EATING DISORDERS RECOVERY CENTER OF ATHENS
Provides individual and group therapy
Minou Rysiew, LCSW
706-552-0450

PEACH COUNTY AREA

PRIVATE PRACTICE
Joyce Mack-Leonard, LMFT
Provides individual, couples and family therapy
478-922-8999

In Alabama:

MONTGOMERY AREA

TRANSFORMATION
Farzaneh Guillebeaux, LPC
A private practice that provides individual, family and group therapy
334-318-5441