The Pennsylvania State University

The Graduate School

College of Education

AN EXAMINATION OF ANXIETY AND OVEREATING AMONG AFRICAN AMERICAN WOMEN: CAN SPIRITUALITY OR CULTURAL IDENTITY ACT AS MEDIATORS?

A Dissertation in

Counseling Psychology

by

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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Philosophy

May 2013

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ABSTRACT

College students are confronted with a variety of stressors including managing academic coursework, navigating relationships, as well as adjusting to campus life. African American students are subject to the additional stressor of racism on a consistent basis. In addition to the pernicious effects of racism, African American women may also be confronted with the negative effects of sexism and classism. These experiences (as an aggregate as well as separately) impact individuals in myriad ways but a commonly reported result is increased anxiety. A frequently utilized coping mechanism to deal with anxiety is overeating. This study posited a positive correlation between anxiety and overeating concerns among a sample of African American college women. Two mediation models were also examined. The first model hypothesized that an individual's spiritual or religious practice could ameliorate the effect of anxiety on overeating. The second model posited that possessing a strong cultural identity would mediate the effects of anxiety on overeating. Results confirmed that anxiety was positively correlated with overeating; however neither mediation model was proven to be true.

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ACKNOWLEDGEMENTS

It is true; Dr. Hayes was correct. The road to earning my doctorate has been a marathon, not a sprint. He told me that during my first year as a student at Penn State. Over the years I have spent working here, I have often reminded myself of the veracity of his words. How sweet it is to have almost arrived at the finish line and to anticipate the gratifying taste of completion.

I wish to thank my advisor and chair, Dr. Jeff Hayes, for his support and guidance throughout this arduous process. I appreciate his suggestions, critiques, and warmth as I navigated the processes of topic selection, literature reviews, methods, and writing about my findings.

I would also like to thank my dissertation committee members: Dr. Louis Castonguay, Dr. Mary McClanahan, and Dr. Janet McCracken. I am grateful for their support throughout my proposal process and for their thoughtful comments regarding the study design. Specifically, I appreciate Dr. McCracken's useful suggestions with regard to additional analyses as well as with defining my variables more clearly. Dr. Castonguay offered helpful ideas regarding alternative relationships among the variables as well as other potential hypotheses.

Finally, I knew I could count on some meticulous editing when I sent Dr. McClanahan my proposal. I am immensely grateful for the time she took to read, critique, and respond to my writing. When a project consumes such an inordinate amount of energy and time, it is gratifying to know that it is thoughtfully and carefully reviewed. It

was enjoyable to read her comments throughout my literature review and helped me to augment this work.

I would be remiss if I did not extend my heartfelt gratitude to Dr. Ben Locke and the Center for Collegiate Mental Health for allowing access to their data. I am so very fortunate to have access to the rich pool of information that has been generated by CCMH.

Finally (but perhaps most importantly), I would like to thank my husband, Jim Geis, for his unwavering support throughout the dissertation writing process. My words here cannot possibly convey adequately the depth of gratitude and love I have for him. Jim's consistent patience, encouragement, grace, and most of all, his love, were invaluable gifts as I navigated this discourse. I am unsure if I could have completed the project without him. Therefore, this finished work is not merely an accomplishment for me, but for us, and is dedicated wholly to him.

Chapter 1

AFRICAN AMERICAN WOMEN, ANXIETY, AND OVEREATING CONCERNS

College students have myriad challenges to negotiate including transitioning into campus life, managing academic pursuits, navigating relationships with peers and family, and possibly fulfilling work commitments. Any and all of the aforementioned challenges can contribute to stress in a student's life. The American College Health Association (2008) notes that students' stress can impede academic performance and can also exacerbate anxiety and depression, which are prevalent diagnoses on college campuses.

Relevant to these diagnoses, there has been a rise in the number of students who seek treatment at college counseling centers over the past twenty years and students are remaining in counseling for longer periods of time than in the past (Lucas & Berkel, 2005; Rando & Barr, 2010; Soet & Sevig, 2006). Anxiety and adjustment disorders are among the most common student problems presented at intake (Center for Collegiate Mental Health, 2010; Stone, Vespia, & Kanz, 2000).

The Challenge of Racism

One subgroup of students who clearly have additional challenges to manage are African American women. In addition to handling their college course work, peer and family relationships, and possible part-time employment, they must also cope with discrimination which is generally attributed to racism, sexism and/or classism. According

to the wealth of literature devoted to this area, racism is by far the most pernicious and prevalent of these three threats. There is an extensive body of literature documenting the troubling frequency with which African Americans experience racism. The widespread prevalence of racist events is true for African American youth, college students, as well as adults (e.g., Bryant-Davis & Ocampo, 2005; Marino, Negy, McKinney, & Asberg, 2007).

The potential to encounter a racist remark, person, or situation is a daily reality for members of ethnic minority groups and for African Americans in particular. In fact, research indicates that by the young age of 12, 90% of African American youth reported already experiencing at least one incident of discrimination during their lifetime (Fisher & Holz, 2000). In a study of college students, most (89%) had heard disparaging comments about African Americans "occasionally" to "frequently" and 59% reported being personally verbally insulted while at college (Swim, Hyers, Cohen, Fitzgerald, & Bylsma, 2003).

In addition to the consistent threat of racism, adjusting to university life may pose a unique challenge to African American students. Navigating a successful transition to campus life may be especially difficult at schools where African Americans represent a minority. In such settings, they report higher levels of alienation and anxiety and lower levels of well-being. In a large, national study of counseling centers (27,616 students), African American students reported more distress than European American students on scales of depression, hostility, family concerns, social anxiety, and academic distress (Hayes, Chun-Kennedy, Edens, & Locke, 2011). Anxiety, anger, and overall psychological distress were also higher in African American students than European

Americans in an earlier study by Myers, Lesser, Rodriguez, Mira, Hwang, Camp and Wohl (2002).

As university populations continue to grow in the ethnic diversity of their student bodies, it becomes necessary to gain a more intricate understanding of the mental health needs of diverse students. Being armed with information relevant to specific subgroups of clients will help counselors to develop appropriate empirically supported treatment plans and reliable outcome measures (Stone, Vespia, & Kanz, 2000). With such a high incidence of discriminatory/racist events affecting African American students in particular and the unique challenges related to being a member of an ethnic minority group, it behooves researchers to look into the ramifications of these experiences on the lives of African Americans and into ways to address the resulting difficulties. As such, this study will focus on increasing understanding of one sub-group of students: African American women.

Anxiety and Eating Problems

One major byproduct of experiencing discrimination is anxiety, and African American women often deal with these anxious feelings by overeating (Striegel-Moore, Fairburn, Wilfley, Pike, Dohm, & Kraemer, 2004; Talleyrand, 2006). Overeating is a problem for many Americans; however, overall, African American women have the highest prevalence of being overweight and/or obese in the United States (e.g., Davis, Rovi, & Johnson, 2005; Lovejoy, 2001; Mitchell & Mazzeo, 2004; Pleis & Lucas, 2009). The National Institute of Diabetes and Digestive and Kidney Diseases estimates that 49%

of African American women are obese (Pleis & Lucas, 2009). This is in contrast to 33% of White women who are obese, and 43% of Hispanic women.

There are several theories about this disproportionate incidence of obesity. One reason is that the Black culture exhibits greater acceptance of diverse body types rather than idealizing thinness (as in White culture). Obesity is certainly not as stigmatized in African American culture as it is in dominant, White American culture (Mitchell & Mazzeo, 2004; Smolak & Striegel-Moore, 2001). Another reason for the high incidence of obesity in African American women is that coping with emotions through binge eating is considered acceptable and the resulting obesity does not violate cultural standards of beauty (Wildes, Emery, & Simons, 2001). Such coping is often in response to anxiety related to marginalized status. Consequently, excessive eating is frequently a response to contextual stressors such as racism, sexism, and/or classism. There is empirical evidence suggesting that African American women engage in binge eating behavior in equal or greater rates than their White counterparts (Striegel-Moore, Wilfley et al., 2000; Talleyrand, 2006). Binge eating to alleviate societal stressors (e.g., racial stressors) may be considered a risky health behavior since it may contribute to obesity and related negative health outcomes in African American women. As a result of the high rates of obesity, African American women experience higher disease and illness rates and more chronic conditions (such as hypertension and diabetes) in comparison to European Americans (Myers et al., 2002).

Can Spirituality Make a Difference?

Religious and spiritual orientations have proven to be beneficial to people in terms of both mental health and physical health. Among other qualities, religion and spirituality have repeatedly emerged as important predictors of general life satisfaction, existential well-being, and overall happiness (Koenig, McCullough, & Larson, 2001). In addition, having a spiritual life has been shown to increase emotional well-being (Frazier, Mintz, & Mobley, 2005), to help in coping with depression and anxiety (Hodges, 2002), and to facilitate resilience (Bartlett, Piedmont, Bilderback, Matsumoto, & Bathon, 2003). Koenig's (2009) meta-analysis of religion, spirituality, and mental health revealed that those who were more religious often experienced less anxiety than those who were less religious. Though not all forms of religiousness are related to positive mental health (Hill & Pargament, 2003), there is ample evidence that religion is generally a positive influence in the lives of subscribers.

Religion, Spirituality, and African American Women

Traditionally, African American women have been active members of Christian churches and this involvement continues to play a role in the promotion of individual physical and emotional health in those communities (Douglas, Jimenez, Lin, & Frisman, 2008). In addition to the support one feels from being connected to a higher power, there is also tremendous value garnered from being a member of a church community. The church does not merely provide a setting for prayer, worship and faith sharing; African Americans perceive their churches as venues for sustenance, strength, assistance, and moral guidelines for conduct. The church is also viewed as a place of unity, community

gathering, and aid in attaining social, economic and educational goals (Frazier et al., 2005).

As was stated earlier in this chapter, there is overwhelming support for a positive relationship between religious involvement and psychological adjustment, and African Americans are not an exception to this finding. Strong associations have been found between religiosity and various indicators of mental health and well-being among African Americans. Among other benefits, religion has been found to promote personal well-being and to mediate negative outcomes for African American adults. In addition to the positive correlations between religiosity and positive well-being, religious variables are also linked to positive self-esteem, coping skills, and less distress. Jang and Johnson's (2004) study of African American adults demonstrated this point. Using a national sample, the researchers found that religiously committed African Americans exhibited lower levels of distress than their less religious or nonreligious counterparts. Highly religious African Americans reported feeling more of a sense of control and social support, which consequently reduces distress and anxiety.

African American women's spirituality is unique in that it is based on a strong sense of communalism reflected in kinship ties, emphasizing their relationship to others, as opposed to White, middle-class society's values of independence and self-sufficiency. Their spirituality involves a God who is intimately aware of the details of their lives and is concerned for them. Such concern by a loving God engenders self-esteem and optimism despite adversity (Banerjee & Pyles, 2004). This strong sense of support may help to alleviate feelings of anxiety in women and help to prevent overeating in order to deal with difficult emotions. It appears that religion may affect well-being by providing

concrete strategies for coping with distress and adversity and by providing real and/or perceived emotional and moral support. The benefits of possessing a religious and/or spiritual orientation are clear. Can such an orientation act as a mediating factor with anxiety and overeating concerns among African American college women?

Cultural Identity and Mental Health

Religion and spirituality are not the only factors that can positively impact anxiety (and ensuing eating problems) in African American women. Possessing a strong cultural identity has been shown to be a protective (mediating) factor against anxiety and depression in African American adolescents (e.g., Gaylord-Harden, Ragsdale, Mandara, Richards, & Petersen, 2007; Stevenson & Arrington, 2009) as well as in adults (e.g., Jones, Cross, & DeFour, 2007; Outten, Schmitt, Garcia, & Branscombe, 2009).

One of the mechanisms through which cultural identity acts as a buffer against anxiety and depression is through improving self-esteem. A strong cultural identity can bolster self-esteem among members of minority groups (Outten et al., 2009). Such an increase in self-esteem fortifies an individual's ability to cope with the pervasive devaluation and rejection that is associated with minority group status. This enriched self-esteem and coping capacity also protects against anxiety and depression.

Identifying with one's group in response to feelings of mistreatment is inversely related to depressive symptoms, psychological distress, and low self-esteem (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003). When individuals feel marginalized and devalued, identifying with the collective disadvantaged group can buffer the negative effects of unjust treatment. Furthermore, identifying with and investing more in the

devalued group can have positive consequences for psychological well-being. Finally, with regard to the association between ethnic identity and self-esteem, negative and less developed ethnic identity are both associated with higher levels of depression and anxiety in African American adolescents and college students (Roberts, Phinney, Masse, Chen, Roberts, & Romero, 1999; Yip, Seaton & Sellers, 2006).

The Current Study

The present study will test two mediation models. In both models, anxiety (the predictor variable) is thought to contribute to overeating (the criterion variable) among African American women. The first model posits that spirituality will mediate this relationship and the second model posits that cultural identity will mediate this relationship.

Along with the mediation models, several hypotheses will be tested. First, the supposition that anxiety (the predictor variable) and overeating concerns (the criterion variable) are positively correlated will be tested. Subsequent to this, several other correlations will be analyzed. The mediation models will test whether a mediator (in this case spirituality and cultural identity) can attenuate the impact that anxiety has on overeating concerns.

The following is a list of the hypotheses:

Hypothesis 1: There is a positive correlation between anxiety and overeating concerns.

Hypothesis 2: There is a negative correlation between spirituality and anxiety.

Hypothesis 3: There is a negative correlation between spirituality and overeating concerns.

Hypothesis 4: In the mediation model, spirituality will mediate the effect of anxiety on overeating concerns sufficiently so that the relationship between anxiety and overeating concerns will be significantly reduced.

Hypothesis 5: There is a negative correlation between cultural identity and anxiety.

Hypothesis 6: There is a negative correlation between cultural identity and overeating concerns.

Hypothesis 7: In this mediation model, cultural identity will mediate the effect of anxiety on overeating concerns adequately enough so that the relationship between anxiety and overeating concerns will be significantly reduced.

Chapter 2

A REVIEW OF THE LITERATURE

Over the past twenty years, there has been an increased demand for services in college counseling centers, and students are remaining in counseling for longer periods of time than in the past (Lucas & Berkel, 2005). Specifically, between 2001 and 2006, universities reported a 40% to 55% increase in students coming to counseling (Soet & Sevig, 2006). Anxiety, adjustment disorders, and depression are among the most common problems presented (Center for Collegiate Mental Health, 2010; Stone, Vespia, & Kanz, 2000). Given the increase in both the diversity of student bodies as well as the number of students presenting for help at college counseling centers, it is necessary for clinicians to grow in their understanding of diverse populations. Being armed with information relevant to specific subgroups of clients will help counselors to develop appropriate empirically supported treatment plans and reliable outcome measures (Stone et al., 2000). As such, this study will focus on increasing understanding of one sub-group of students: African American women.

African American Women, Stressors, and Anxiety

College students face multiple stressors as they navigate the challenges of transitioning into university life, growing into adulthood, succeeding academically, developing and maintaining social lives, as well as managing peer and family

relationships. College student development literature asserts that in addition to the challenges all students encounter as they transition into higher education, African American students also encounter specific developmental tasks such as racial identity development and negotiating interactions with the dominant culture (Cole & Yip, 2008). Such a transition may be particularly difficult at schools where African Americans represent a minority. In such settings, they report higher levels of alienation and anxiety, lower levels of well-being, and underperformance relative to their SAT scores compared with their White peers. In addition, African Americans report more anxiety, anger, and overall psychological distress than European Americans (Myers, Lesser, Rodriguez, Mira, Hwang, Camp, & Wohl, 2002).

At the root of these feelings of alienation, anxiety, decreased well-being, and underachievement may be the common experiences of discrimination stemming from racism, sexism and/or classism. Experiences of discrimination present ongoing challenges in the lives of most African Americans, and college students are not exempt. The hurdle of discrimination may be encountered on a daily basis. Virtually an omnipresent stressor in the lives of African Americans, discrimination, perhaps more than other stressors, affects mental health, self-esteem, and even academic performance. Consequently, identifying effective coping mechanisms and encouraging their implementation is a salient issue for university personnel in student affairs, health services, as well as in university counseling centers.

This paper will examine discrimination experienced specifically by African American women. African-American women are said to be challenged by a triple threat: racism, sexism, and classism. These multiple stressors result in a stressful social

environment and consistently impact physical and mental health. In his "minority stress" model, Meyer (2003) explains that members of stigmatized minority groups (such as African American women) are challenged by these stressful social environments which evolve from stigma, prejudice, and discrimination. Faced with the stress of prejudice events, expectation of rejection, internalized racism, and coping challenges on a consistent basis (sometimes even daily), members of minority groups often develop mental health problems. Meyer even argues that members of minority groups have higher rates of mental health diagnoses than members of non-stigmatized, majority groups. This sentiment is echoed by Szymanski and Stewart (2010) who point out the disproportionate volume of psychological distress which members of ethnic minority groups experience as compared to the general population.

Minority stress engendered by racist as well as sexist and classist experiences will be discussed in this paper. Also, gender differences and the effects of these experiences will be discussed. One major byproduct of experiencing discrimination is anxiety, and African American women often deal with these anxious feelings by overeating (Striegel-Moore, Fairburn, Wilfley, Pike, Dohm & Kraemer, 2004; Talleyrand, 2006). This coping mechanism will be examined along with more positive coping strategies. Two positive methods of coping with anxiety will be examined in depth; namely, the use of spirituality and cultural identity as protective factors against anxiety. Finally, implications for clinicians will be discussed.

Discrimination Known as Racism

The term "discrimination" is from the Latin word "discriminationem" and is defined as "the perceiving, noting, or making a distinction between things" (Oxford English Dictionary, 2nd Ed, 1989). A more recent Oxford definition notes also the negative connotation of discrimination: "the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age or sex" (Oxford U.S. English Dictionary, Oxford University Press, http://oxforddictionaries.com, c 2012). To report a behavior as discrimination, an individual must attribute the aversive treatment to one's group membership (Fischer & Holz, 2007). The most widespread type of discrimination experienced by African American individuals is due to their ethnicity and is referred to as racism.

Racism has been defined in a myriad of ways. A popular definition posits that racism is a system of dominance, power, and privilege based on racial group designations (Harrell, 2000). Such systems are rooted in the historical oppression of a group deemed inferior by a dominant group. Members of the dominant group create or accept their privilege by maintaining values and behaviors that leave non-dominant group members relatively excluded from power or equal access to resources. Jones's tripartite model of racism (1997) is more specific. In it, she postulates that there are three types of racism: institutional, individual, and cultural. Institutional racism is defined as values and attitudes that are maintained by racially privileged groups that ultimately serve to exclude racial and ethnic minorities from equal access to societal resources and liberties (Essed, 1991). Individual racism occurs on a personal level such as experiencing a racial slur.

The third type, cultural racism, is the notion that the practices and contributions of racially privileged groups are regarded by society as superior to those of racial and ethnic minorities. Exposure to these levels of racism often co-occurs and therefore, persons of color generally experience racism in various contexts (Harrell, 2000).

Racial oppression involves the mistreatment of a group of people because of their racial differentness or perceived racial inferiority. It may be overt or covert; intentional or unintentional. Abuse can be physical, mental, emotional, or spiritual. Racist events may include physical beatings, sexual assault, belittlement, intimidation, devaluation, stifling growth, and conveying messages that one "should not feel angry" about such incidents (Landrum-Brown, 1990).

Despite societal efforts to level the playing field and to provide equal opportunities for African American men and women, African Americans continue to experience institutional, individual, and cultural racism in multiple forms. In addition to personal encounters with racial profiling or being treated differently from other racial groups, African Americans also frequently face social disadvantages such as residential segregation, fewer educational opportunities, employment limitations, and income disparities (Paul, 2003).

The bulk of the literature references experiences of individual racism (occurring on a personal level) as being the most prevalent and troublesome to African Americans. This emphasis concurs with current theoretical models which suggest that the most potent forms of racist discrimination experienced by African Americans today are personal, subtle, and unconscious slights that are experienced on a daily basis (Tougas, Desruisseaux, Desrochers, St. Pierre, Perrino, & De La Sablonniere, 2004). These often

include being treated as dishonest, threatening, less intelligent than others; being treated with less courtesy or respect than others; receiving poor service in restaurants or stores; and being the target of insults, threats, or harassment (Landrine & Klonoff, 1996). When imagining these events in isolation, they may not seem especially potent or detrimental. However, consider that an African American individual may be poised to encounter any (or all of them) on any given day. These days (during which there is the potential to experience a racist event) accumulate into weeks, months, and then years. Even in the absence of experiencing a racist event, the knowledge that it potentially could occur at any time and the accompanying consistent low level of anxiety that exists prior to an encounter takes an emotional toll. When an experience of racism occurs, this low level anxiety is exacerbated.

In sum, African Americans are constantly aware of the potential to experience racism in both subtle and overt ways. Given the insidious and frequent nature of racism in the lives of African Americans, members of this population are in constant risk of its deleterious effects on health and well-being (Greer, Laseter & Asiamah, 2009; Utsey, Hook, Stanard & Giesbrecht, 2008). As such, it is a topic worthy of exploration and examination for current and aspiring mental health professionals.

Frequency of Racism

African American individuals report higher levels of discrimination compared to White individuals at every level of age, gender, education, and income. In one

community study of experiences of discrimination, 34% of African Americans reported experiencing some form of discrimination within the previous six months such as name calling, refusal of service, unfair job assignments, housing discrimination, and/or police maltreatment (Bryant-Davis & Ocampo, 2005). In another community study of discrimination, 75% of African Americans, compared to 44% of Whites, responded affirmatively to experiencing racial stress (Thompson Sanders, 2002).

A study of college students found those numbers to be even higher with 90% of African-American students and 55% of White students reporting affirmatively to having experienced at least one discriminatory event in their lifetime (Marino, Negy, McKinney, & Asberg, 2007). Yet another study assessed the incidence of racial discrimination in the lives of African Americans and revealed the highest figures: that 98.1% of African American participants had experienced racist discrimination in the prior year, and that 100% reported that they had experienced racism in their lifetime (Landrine & Klonoff, 1996).

Swim, Hyers, Cohen, Fitzgerald, and Bylsma (2003) detailed specific experiences of racial discrimination among African American undergraduates at a predominantly White/European American university and found that 89% had heard disparaging comments about African Americans "occasionally" to "frequently." Additionally, the researchers found that 59% reported being personally verbally insulted and that 36% reported experiencing incidents involving threats or violence while at college. Fully 70% of those who experienced prejudice reported feeling extremely upset by the incident.

The above findings with college students and adults parallels research with youth which has shown that African Americans experience more discrimination than European

Americans and that the subjective ratings of impact of discrimination is more negative for African Americans than it is for European Americans. In studies of youth ranging in age from 10 to 19 years old, African American youth experienced significantly higher levels of racial discrimination than European American, Latino and Asian youth. By the age of 12 years old, 90% of African American youth reported already experiencing at least one incident of discrimination during their lifetime. These incidents included being harassed by store personnel, experiencing others' low expectation due to their race, being excluded from social organizations, being wrongly or unfairly disciplined at school, and being threatened or called a name (Fisher et al., 2000). With such a high incidence of discriminatory/racist events affecting a group of people, it behooves researchers to look into the ramifications of these experiences on the lives of African Americans and into ways in which to address the resulting difficulties.

Effects of Racism: Gender Differences

Though all African Americans are susceptible to racism and its accompanying distress, there are differences between how men and women process and experience its effects. African American men report higher levels of perceived discrimination than African American women. However, African American women report experiencing more anxiety and depression related to discrimination (Banks et al., 2006). Women in general are more likely to ruminate on stressors which can exacerbate symptoms. Faced with discrimination, they may internalize their struggles leading to feelings of anxiety or depression. Men, when confronted by discrimination, are more likely to engage in

externalizing coping strategies such as substance use or athletic involvement (Rusting & Nolen-Hoeksema, 1998).

Despite being more distressed than African American men, African American women are less likely to engage in interpersonal aggression. There are several reasons cited for this, including that African American women are (1) better protected by the distress buffering effects of religion as well as its deviance-reducing effects; and (2) they are more likely to experience self-directed distress (depression and anxiety) in response to strain rather than other-directed distress such as anger (Jang & Johnson, 2005).

African American Women and the Triple Threat of Racism, Sexism, and Classism

Racism and Sexism as Stressors

Though the effects of racism reach all African Americans, women are affected uniquely since they hold membership in two oppressed demographic groups: that of being African American and of being female. Such affiliations subject them to the unique challenges of racism and sexism (Talleyrand, 2006). Ethnic minority women are exposed to various forms of racism and sexism that come from a variety of places including interpersonal relationships, workplaces, media, and legal systems (American Psychological Association, 2007). Such discrimination can result in obvious (external) prejudice and harassment and often engenders negative feelings about oneself or about one's ethnic group (Swim et al., 1988; Szymanski & Stewart, 2010). Since women of color face both racism and sexism, they often find themselves in "double jeopardy" or

"multiple jeopardy" as some theorists refer to it (Moradi & Subich, 2003). When examined separately, perceived sexist and racist events are related positively to psychological distress.

At times, sexist and racist events combine and create a unique form of discrimination known as gendered racism. This term is used to describe how sexism and racism combine under certain conditions into one phenomenon (Essed, 1991). This "double strike" often makes it difficult for victims and researchers to parse out the separate contributions of racism and sexism in situations of discrimination. The combination of being a woman, having greater stress, and facing greater racial discrimination predicted increased psychiatric symptoms for African American women as compared to African American men and to White women (Thomas, Speight, & Witherspoon, 2008).

In an effort to understand how women experience racism and sexism simultaneously, Jones and Shorter-Gooden (2003) conducted a national study and found that African American women experienced pervasive stereotypes, including the expectation to placate and serve others, the inferiority of African American women, and sexual promiscuity. They reported being mistreated by law enforcement and by store employees. Women in the workplace reported experiencing the most discrimination, but found it difficult to distinguish whether discrimination occurred due to race, sex, or a combination thereof.

The author of one study (who is an African American woman) cited an example of gendered racism she experienced as she rode in a hotel elevator with a White man. Both were guests of the hotel. The White man addressed the African American woman

saying, “You work here. What time does the breakfast start?” The man’s apparently racist and sexist views facilitated his assumption that the African American woman was a service worker in the hotel (Thomas et al., 2008).

The erroneous assumption that an African American woman was a member of the service industry may also be linked with roles that they have often held. Historically, African American women have been expected to work outside of the home, to provide for their families, and to care for others. They were forced to take on these multiple roles due to the absence of their husbands or the fathers of their children during the eras of slavery and post-reconstruction (Malson, Mudimbe-Boyi, O’Barr, & Wyer, 1990). Not only were women expected to work, they were often in jobs typically reserved for men; working in the fields doing manual labor. In nineteenth century America, traditional gender role stereotypes resulted in social conventions that prohibited females from many forms of labor that were routine for males. This protection of femininity was not extended to African American women, either during or after slavery. Typically, these women worked in the fields alongside African American males or served as domestics: cooking, cleaning and providing childcare for the slave owner’s children (Greene, 1994).

Post slavery, the expectation that a Black woman would manage multiple roles of mother, wife, and worker continued. Unlike their White counterparts, African American women were consistently expected to work outside of the home. Even when a Black woman had a male partner who was free of slavery and was employed, she was still expected to work outside of the home because the family relied on two incomes in order to survive. Though new opportunities slowly emerged for the Black woman, her job opportunities often remained quite similar to those that were available during the era of

slavery: namely, she could work as a domestic servant or as a field hand. Due to the low wages and opportunities of the era, both heterosexual couples and single African American women struggled for a meager existence (Dunston, 1990).

Consequently, African American women have been socialized to care for others before caring for themselves. In addition, they have been taught to maintain a façade of independence and strength despite stressors they might be experiencing. This need to portray an image of survival and strength combined with the consistent threat of being victimized by racism may negatively impact physical, mental, and spiritual well-being (Thomas et al., 2004).

Classism as Stressor

In addition to the stressors of racism and sexism, African American women often experience the effects of classism. Collins and Yeskel (2005) define classism as "the assignment of characteristics of worth and ability based on social class; the attitudes, policies, and practices that maintain this unequal valuing; and the systematic oppression of subordinated groups (people without endowed or acquired economic power, social influence, or privilege) by the dominant groups" (p. 143). Classism entails a devaluing of those who lack economic resources and often intersects with racism, sexism, heterosexism and ableism. Some of the manifestations of classism are easily identifiable, and others are more subtle and are often perpetuated by well-intentioned people who are unaware of the classist implications of their thoughts or actions.

Though social stratifications and prejudices have existed throughout history, an increasing number of Americans have been affected by it during the 20th century. This is largely due to the widening economic gap between the top and bottom of the economic spectrum in our country. Termed "economic apartheid," it has resulted in rising levels of poverty and hunger. Among working people, wages have stagnated, and more working households are without pensions, health insurance or personal savings despite the increase in the overall number of hours worked per week (Smith, 2008).

How are these socioeconomic issues relevant to African American college students? An increasingly broader spectrum of socioeconomic statuses are represented on college campuses, including a number of students who come from low-income families. In a 2010 survey of African American students at a large, public university, 13% reported a family income that was in the "poor" range and 23% reported a family income that was categorized as "lower income" (Fhagen-Smith, Vandiver, Worrell, & Cross, 2010). According to the U.S. Census Bureau, for a family of four, an income level that was less than $20,000 in the year 2000 was considered living at the poverty threshold (U.S. Census Bureau, 2000; as cited in Fhagen-Smith et al., 2010). These figures indicate that 36% of the African American students were of low socioeconomic status and likely would be affected by challenges related to low SES.

The current study utilizes a national sample of African American, female college students. In this specific data set, most indicated that they had experienced financial stress at least some of the time (Item numbers 57 and 58 on the SDS). In addition, most (60%) of the African American women in the study are the first in their family to attend college (Item number 56 on the SDS).

Given all of the aforementioned statistics, it seems fair to say that classism is a relevant issue for at least some African American students and will be considered as a pertinent member of the triple threat (racism, sexism, and classism) that African American women consistently encounter.

Classism and African Americans

Though it affects many Americans, classism disproportionately affects African Americans compared to their White counterparts. This is one of the legacies of the American slavery movement. Consequent to decades of enslavement, few rights with regard to acquiring or maintaining ownership of property, and minimal education, there exists a vast racial wealth divide. Typically, African Americans own less than a dime for every White dollar owned (Lui, Leondar-Wright, Brewer, & Adamson, 2006 as cited in Smith, 2008). African Americans are more likely to live in poverty, experience prolonged unemployment, be incarcerated, become homeless, live in a high-crime neighborhood, and have fewer financial resources. In 2010, the poverty rate for African Americans was 27.4% as compared to 9.9% for non-Hispanic Whites (National Poverty Center, 2010). Though several of the aforementioned statistics (e.g. unemployment, homelessness) likely do not pertain to a sample of college students, it could pertain to members of their families.

Women across all racial groups are 40% more likely to live in poverty than men and African American women are even more likely to experience classism since they have less access to positions of power and authority than both White individuals (male

and female) as well as Black males. Black women who are the head of the household (without a spouse or partner present) account for 39% of African Americans living below the poverty line (National Poverty Center, 2010). This last statistic regarding acting as head of a household is likely not relevant for the majority of college women in the current study, but it could very well relate to the homes where they grew up and to their mothers, who may have been single parents.

When individuals lack economic resources, they are at risk for experiencing health concerns including anxiety, depression, and physical illness (Dounchis, Hayden, & Wilfrey, 2001). Such individuals are also less likely to have consistent access to health care. Similar to the frequent intersection of racist and sexist events, classist attitudes and systems often coincide with racist and sexist experiences and it is sometimes difficult (if not impossible) to separate which of the three is exacting the negative emotional toll on its victim.

Racism, sexism, and classism are painful realities in the lives of many African American women. The consequences of experiencing racism, sexism and/or classism vary by person, but generally include both emotional and physical effects. Some commonly reported and observed effects are explored below.

Effects of Racism, Sexism and Classism

Effects of Racism

Experiencing racism tends to be associated with adverse psychological and physiological outcomes. Williams and Mohammed (2009) reviewed 115 studies conducted between 2005 and 2007 that examined the association between racism and health. Across an international span of ethnic groups, racist experiences were inversely related to mental and physical health. Carter (2007) conducted a similar review with a U.S. sample and came to the same conclusion; racist encounters and experiences are correlated with diminished mental health. Consistent with the findings above, Lee and Ahn (2011) found a small average correlation between racism and psychological distress (r = .23). Clearly, racism negatively impacts members of minority groups. Though racism and discrimination are examined in the literature, there is a dearth of studies examining the effects of racism on African Americans exclusively. This is surprising given that African Americans report higher levels of exposure to discrimination and racism than do other ethnic groups (Pieterse, Todd, Neville, & Carter, 2012).

Most of the research on discrimination and racism has focused on African American adults as opposed to youth or to female college students. In addition, the majority of studies examine the impact of racial discrimination on physiological functioning (such as increased heart rate and hypertension as a result of stress) rather than on the psychological effects of racism (Williams, Neighbors, & Jackson, 2003). However, some researchers have looked to examine the emotional ramifications of

experiencing racism and have found that stress, anxiety, and depression are the most commonly reported effects

In a 2012 meta-analysis on the associations between racism and mental health among African Americans, Pieterse et al. reviewed 66 studies. Using a random effects model, the authors found a positive association between racism and psychological distress (r = .20) among African Americans. Specifically, the relationships between perceived racism and self-reported anxiety and depression were statistically "robust" adding support to the notion that racism is distressing and negatively impacts mental health.

In their 2006 study, Banks et al. hypothesized (1) that perceived discrimination would be associated with depressive symptoms and anxiety symptoms for African American men and women. They also hypothesized that (2) gender would moderate the relationship between perceived discrimination and depressive symptoms and perceived discrimination and anxiety symptoms. In particular, Banks et al. hypothesized that for women, these associations would be stronger. The study involved structured interviews of 570 adults (180 males, 390 females) who self-identified as African American. As predicted, perceived discrimination was associated with increased anxiety and depression in African American men and women. *T*-tests revealed that women reported significantly more anxiety symptoms than men. However, no gender differences were found in depressive symptoms. This is in alignment with findings from college student research highlighting the top problems presented by racial minority students at counseling intake sessions. They included stress management, depression, academic concerns, and relationship difficulties (Lukas & Berkel, 2005).

A 2006 study illustrated this point. In it, Sellers, Copeland-Linder, Martin, and Lewis examined the association between self-reports of racial discrimination and self-reports of depressive symptoms in a sample of 314 African American youth recruited from public schools. Results demonstrated that frequency of racial discrimination was directly and positively associated with depressive symptoms. Though some studies have shown that individuals with elevated anxiety and depression perceive more racial discrimination, this was not the case for this study. The five-year longitudinal nature of the study demonstrated that the opposite was true: individuals who perceived more racial incidents did not score higher on depression or anxiety at the start of the study. Instead, perceived racial incidents were correlated with increases in pathology over the years of the study.

Other studies also indicate that perceived discrimination exacts an emotional toll and is directly positively related to symptoms of depression and anxiety. In a 2007 study of 1000 undergraduate college students, 99.4% of African Americans reported that racism was a source of stress (Marino et al., 2007). The results of these studies confirm the findings of a 1983 National Institute of Mental Health (NIMH) study citing depression, anxiety, and rage about racism as the most prevalent mental health problems presented by African Americans in psychotherapy (NIMH, 1983).

The concept of race-related stress was derived from Lazarus and Folkman's transactional theory of stress (Lazarus & Folkman, 1984). In it, Lazarus and Folkman postulate that stress is the product of person-environment interactions in which situations and problems are appraised by individuals as taxing or exceeding available resources. This theory easily translated into stress specifically related to race. Race-related stress is

defined as race-related transactions occurring between the environment and individuals that are perceived as racism-related and that tax available resources (Harrell, 2000).

Besides contributing to symptoms of depression and anxiety, race-related stress can affect identity development and self-esteem (Comer, 1995). Negative evaluations of one's group can affect one's self-perceptions, complicate the identity development process, and contribute to poor self-concept. Consequently, race-related stress predicts poorer mental health in youth including symptoms of depression and anxiety. This was exemplified in a 2009 study of adolescents. In it, 268 African American youth (mean age 12.9; 56% female) from low-income communities were surveyed. Hierarchical regression analyses indicated that discrimination stress was positively associated with depression and anxiety (Gaylord-Harden & Cunningham, 2009). In addition, Bryant-Davis and Ocampo (2005) found that racism was a chronic stressor for African Americans and negatively impacted their psychological well-being. Among other statistics, they reported that 40% to 67% of participants reported ethnic harassment which related to lower well-being (even after controlling for personality factors). The authors postulated that racist incidents can result in trauma symptomology including cognitive difficulties, shock, dissociation, shame, challenges with trust, and self-harm behaviors (including substance abuse and disordered eating). Racist experiences have been linked to cardiovascular and psychological reactivity, psychological distress, and depressive symptoms in African Americans (Williams, Neighbors & Jackson, 2003). Swim et al. (2003) found that African American college students who experienced racism endorsed feeling anxiety and anger following the incidents and female students especially felt that they needed to talk

to a trusted confidante about the incident. Certainly, discrimination is affecting the mental health of African Americans and particularly college students.

It would be presumptuous and simplistic to assume that all African American students who present for counseling are suffering from anxiety or depression solely related to racism. However, racism-related experiences may subtly impact their lives and have a cumulative effect which may take the form of anxiety, stress, and/or depression. Of course, there are many factors apart from discrimination in an individual's life that may also contribute to feelings of anxiety and depression. Family problems, academic concerns, community stressors and low socioeconomic status can exacerbate anxiety and depression in youth. However, some studies (e.g., Gaylord-Harden & Cunningham, 2009) have controlled for the effects of gender and stressors related to family, peer, school, and community problems and still found that discrimination stress had a significant effect on internalizing symptoms.

Sexism and Health

Sexism frequently intersects with classism as is illustrated by the fact that women are 40% more likely to live in poverty than are men. Sexism also intersects with race in the statistics on poverty. Not only are women more likely to live in poverty, but the highest rates of poverty in the country belong to single, African American and Latino mothers (National Poverty Center, 2010). With low socioeconomic status comes decreased access to healthcare and the inverse relationship between health and social class. Among other problems, these women are at increased risk for hypertension,

diabetes, and obesity (Smith, 2008). (African American college students come from a range of socioeconomic statuses including from single parent and low-income households. If they grew up in poverty, they may have been exposed to poor eating habits due to the household budget and/or due to attempting to manage emotions through food).

In addition to social class, sexism also intersects with the race issue. African American women are exposed to greater environmental stress than European Americans due to myriad factors but the most detrimental factor may be racial discrimination. Several studies have found that racial stress is associated with negative physical and mental health outcomes among African Americans (Macera, Armstead & Anderson, 2001; Mitchell & Mazzeo, 2004; Talleyrand, 2006). Specifically, racial stressors contribute greatly to anxiety and depression as well as to physical illness (e.g., hypertension) in African American women (Barnes et al., 2005; Talleyrand, 2006; Thomas et al., 2004). Compulsive or binge eating behaviors may also typify those African American women who internalize racial oppression or reject White cultural standards of beauty (Mastria, 2002). Black women's eating habits have been conceptualized as a means of coping with the emotional pain of sexism, racism, and poverty. Eating is often labeled as "a source of comfort and security" in a world where they were made to feel as if they were "absolutely nothing" (Striegel-Moore et al., 2004, pp. 914). Eating and health concerns of African American women may be related to their twofold marginalized status of being Black and female. Given the high rates of disease and health concerns in this community, it would benefit both clients as well as mental health professionals to increase their understanding of how racism and sexism may contribute to eating symptoms in this population.

Classism and Health

As was mentioned previously, there is an inverse relationship between health and social class. Relevant to this paper, African American women of lower socioeconomic status typically experience negative effects of classism. This is because they are at much higher risk for problems than African American women in higher socioeconomic brackets. Among other physical challenges (e.g., hypertension, diabetes), they are at higher risk of developing obesity, binge eating behaviors, and/or binge eating disorder. Research has found that women of color who were interviewed reported that they use emotional eating as a means to cope with poverty-related stress and anxiety. Striegel-Moore et al. (2001) found that African American women had higher rates of recurrent binge eating than European American women and that binge eating was associated with greater psychological distress. Additionally, those who struggle with poverty may maintain diets high in fats and refined sugars (Dounchis et al., 2001; Paul, 2003) as these types of foods tend to be less expensive and easier to access than fresh foods. Therefore, it seems that African American women of lower socioeconomic status may be at heightened risk for becoming obese and for engaging in binging behaviors.

Coping with Anxiety Related to Racism, Sexism, and Classism

Lazarus and Folkman's (1984) model of stress and coping defines coping strategies as cognitions and behaviors that are directed at managing a problem and its attendant negative emotions. African American women employ multiple strategies as they navigate the stress of racism, sexism and classism. Some common coping strategies

employed are: utilizing prayer and spirituality, drawing strength from African American ancestors, sustaining a positive self-image, problem-solving, and seeking social support (Shorter-Gooden, 2004). Professional services are often not sought out even when serious mental health problems are evident (Caldwell, 1996). Some of these positive coping strategies will be discussed more fully later in this paper.

Two commonly used negative coping strategies are avoidance and overeating. These are negatively related to self-esteem and life satisfaction (Barnes et al., 2005; Utsey & Ponterotto, 2000b). Despite the long term negative consequences, as African American women cope with feelings of anxiety, they may turn to food as an immediate source of comfort. When individuals overeat, they may experience (albeit temporarily) a sense of pleasure and comfort that may provide a welcome relief from the anxiety or stress that he or she may be experiencing.

Eating Disorders and African American Women

Eating disorders have long been primarily associated with White females of middle and upper class socioeconomic status. Since eating disorders are assumed to be rare in African American women, both clinicians and nonprofessionals underestimate the prevalence of disordered eating behaviors in women of color (Becker, Franko, Speck, & Herzog, 2003; Striegel-Moore et al., 2004). Additionally, African American women are less likely than White women to seek treatment for eating concerns. Despite the reluctance to seek help, there are a growing number of documented cases of eating disorders in African American women. In particular, African American women exhibit high rates of binge eating behaviors that may meet criterion for binge eating disorder (BED) (Talleyrand, 2006). Binge eating behaviors without compensatory purging behaviors often result in individuals being overweight or obese.

Obesity and African American Women

The term "overweight" is used to describe individuals with an excessive amount of body weight that may come from muscles, bones, adipose (fat) tissue, and water. Someone who is very overweight is considered to be obese. Obesity refers to those who have an excess amount of adipose (fat) tissue. Obesity is considered to exist in individuals who have a body mass index (or BMI) of 30 or more and/or weighing more than 20% above the upper limit for height (Davis, Rovi, & Johnson, 2005). As a group, African American women have the highest prevalence of being overweight and/or obese in the United States. Statistics vary by study but all of the data are in agreement that the

highest rates of obesity are consistently found in African American women (Lovejoy, 2001; Mitchell & Mazzeo, 2004; Pleis & Lucas, 2009). The National Institute of Diabetes and Digestive and Kidney Diseases estimates that 49% of African American women are obese (Pleis & Lucas, 2009). This is in contrast to 33% of White women who are obese, and 43% of Hispanic women.

A University of Florida health survey of Black and White adults (non-students) yielded similar data to the study above. The researchers found that 46% of African American women were overweight as compared to only 18% of White women (Rand & Kuldau, 1990). Another study noted that obesity was a health problem for 60% of middle-aged Black women (non-students) and 30% of middle-aged White women (Wing, 1993). There are several theories about why the highest proportions of obesity are found in one population of women. One reason is that the Black culture exhibits greater acceptance of diverse body types rather than idealizing thinness (as in White culture). Obesity is certainly not as stigmatized in African American culture as it is in dominant, White American culture (Mitchell & Mazzeo, 2004; Smolak & Striegel-Moore, 2001). In fact, although African American women typically have greater body mass indices (BMI's) than their European American counterparts, they are generally more satisfied with their bodies. This acceptance may serve as a protective factor against developing restrictive eating disorders (anorexia, bulimia) in the community.

Another reason for the high incidence of obesity in African American women is that coping with emotions through binge eating is considered acceptable and the resulting obesity does not violate cultural standards of beauty. Other reasons for high percentages of obesity in African American women include anxiety related to marginalized status.

Excessive eating is often a response to contextual stressors such as racism, sexism, or classism. There is empirical evidence suggesting that African American women engage in binge eating behavior in equal or greater rates than their White counterparts (Striegel-Moore, Wilfley et al., 2000; Talleyrand, 2006). Pike et al. (2001) found that African American women were more likely to be obese and to engage in a greater number of binge episodes per week. Engaging in binge eating to alleviate societal stressors (e.g., racial stressors) may be considered a risky health behavior since it may contribute to obesity and related negative health outcomes in African American women. As a result of the high rates of obesity, African American women experience higher disease and illness rates and more chronic conditions (such as hypertension and diabetes) in comparison to White Americans (Myers et al., 2002).

Though African American women's experiences include the range of eating concerns and disorders (anorexia, bulimia, binge eating disorder), this paper will focus on binge eating and behaviors as the potential ensuing obesity is a widespread health problem in the African American community.

Binge Eating and Overeating

Among college women, as many as 60% report (sub-clinical) eating disturbances such as binge eating or chronic dieting (Lester & Petrie, 1998). The question of ethnic differences in eating disturbances has been of interest in the last few years. Community researchers found that the overall prevalence of binge eating behaviors in minority women were comparable to rates in White women (Both were at 8.4%). However,

African American women reported that they engaged in binge eating more frequently and regularly than the White sample. (The African American sample of binge eaters reported at least two binge episodes per week for the prior three months; Marcus, Bromberger, Wei, Brown, & Kravitz, 2007). At an historically Black university, Lester and Petrie (1998) found that 71% of the women engaged in episodes of binge eating, 51% used restrictive dieting, and 44% used fasting as a means of controlling weight. Such high figures are surprising given the reportedly protective factors associated with attending a university where one is a member of the majority (as opposed to being a minority in a predominantly White university).

Among women who seek treatment for eating disorders and eating concerns, anxiety, and depressive disorders are quite common and typically manifest prior to the onset of disordered eating (Godart, Flament, Perdereau, & Jeammet, 2002). For example, in a study of 259 college women (69% European American women and 33% African American) researchers found that anxiety was the most significant predictor of disordered eating for African American women ($r = .489$, $p < .01$), while depression was the primary predictor for eating disorder symptoms in European American women ($r = .251$, $p < .01$; Mitchell & Mazzeo, 2004). The study reinforces the notion that for African American women, food can be a buffer between them and their anxiety.

A 2002 study conducted by Bulik, Sullivan, and Kendler found that in both normal weight and obese women who engaged in binge eating behaviors, there were increased psychiatric and medical problems compared to women who did not binge eat. Problems associated with binge eating included higher prevalence of depression and anxiety, as well as lower self-esteem and self-efficacy. Medical problems associated with

binge eating included earlier onset of obesity and greater weight fluctuations. With obesity comes increased risk for diabetes mellitus, cardiovascular disease, hypertension, and osteoarthritis.

Prior to Binge Eating Disorder (BED) being considered its own disorder in the DSM, the term "Eating Disorder Not Otherwise Specified (EDNOS)" was used to describe 4 types of eating behaviors, one of which is binge eating behaviors without the compensatory purging that is found in bulimia. In a rare study of eating behaviors of African American college women, Mulholland and Mintz (2001) found that none of the sample fit DSM criteria for anorexia or bulimia. However, 2 to 3% were classified as having an eating disorder not otherwise specified (EDNOS). Although there is no conclusive evidence that these students had binge eating type behaviors (as opposed to restrictive eating behaviors), it shows that a potential 3% of collegiate African American women acknowledged binge eating behaviors.

In another (rare) study that examined eating behaviors and included African American women, Striegel-Moore et al., (2003) found that 1.4% of African American women met the criterion for BED. Participants were women who participated in the 10-year National Heart, Lung, and Blood Institute (NHLBI) Growth and Health Study and included 1,061 Black women (mean age=21.5) and 985 White women (mean age: 21.3 years).

There are several factors which help to ease the anxiety (and ensuing eating concerns) which African American women experience. Two such mediating factors are religious practice/spirituality and possessing a cultural identity. Both of these topics will be discussed more fully in the following sections.

Spirituality/Religion as a Protective Factor

The Relevance of Religion and Spirituality

Over fifty years ago, William James, Gordon Allport, and Victor Frankl (as cited in Piedmont, 1999) all acknowledged the positive psychological role that faith, spirituality, and transcendence can play in people's lives. James (1902, 2002) asserted that having a transcendent, spiritual component to life provides meaning and helps to answer fundamental questions. Allport (1960) acknowledged faith and religion as an aspect of personality unto itself and alleged that it can help to provide meaning and peace. Frankl (1963) advanced the field of existential psychology by writing about humans' desire to find meaning and purpose in life, and by pointing out our unique ability to transcend the self (Piedmont, 1999). Over five decades later, it seems that these notions are being recognized as valuable tenets in not only the transpersonal and existential realms but also in mainstream psychological literature.

Nearly 96% of Americans believe in God or a universal spirit and over 90% are affiliated with a formal religious tradition (McCullough, Larson, Hoyt, Koenig, & Thoresen, 2000). Among Americans, 60% feel that religion is "very important" in their lives and 67% are members of a local religious body (Gallup, 1995). Given the fact that so many Americans value a faith system, it seems reasonable to assert that faith must be providing them with some desired benefits and is a positive factor in their lives. In fact, religious and spiritually-oriented lifestyles are becoming increasingly connected

empirically with positive mental and physical health (e.g., Hodges, 2002; Koenig, 2009; McCullough et al, 2000).

In the past, religious and spiritual phenomena have typically been dismissed in psychological circles as being "unscientific" and even "immature" (Piedmont, 1999). However, various facets of psychology, especially clinical and health psychology, are becoming aware of the salience of religious concerns in people's lives, and the impact that these concerns have on mental, physical, and interpersonal outcomes (e.g., Koenig, McCullough & Larson, 2001; McCullough, Larson, Hoyt, Koenig & Thoresen, 2000; Paloutzian & Kirkpatrick, 1995). Historically, religion and spirituality have been at the center of African American community life. However, social science research on the role of religion and spirituality in the lives of African Americans has remained limited. This is relevant to a larger issue in psychology, namely the aforementioned reluctance to engage in scholarly research regarding religion and spirituality (Hill & Pargament, 2008). Weaver et al. (1998; as cited in Hill & Pargament, 2008) conducted a systematic review of research on religion and/or spirituality in articles published in APA journals and found that only 2.7% of quantitative studies included a religion or spirituality variable.

There are numerous reasons for professionals in psychology to eschew the topic. First, psychological theorists, researchers, and clinicians have labored for years to establish the field as a "legitimate" science. This has often entailed favoring logic, reason, and empirical evidence. Often, religion is regarded as unscientific and even irrational. Second, empirical evidence indicates that psychologists are notoriously non-religious people and sometimes even antagonistic towards religion (Mattis & Jagers, 2001). Given

the low percentage of psychologists who embrace religion and its benefits, it stands to reason that many do not realize how profoundly (and positively) religion can shape the lives of those who define themselves as spiritual or religious.

Reaping the Benefits of Religion

Among other qualities, religion and spirituality have repeatedly emerged as important predictors of general life satisfaction, existential well-being, and overall happiness (Koenig, McCullough & Larson, 2001). In addition, having a spiritual life has been shown to increase emotional well-being (Frazier, Mintz & Mobley, 2005), to help in coping with depression and anxiety (Jansen, Motley & Hovey, 2010; Hodges, 2002), to decrease depression (Smith, McCullough, & Poll, 2003), and to increase positive health perceptions which may in turn facilitate resilience (Bartlett et al., 2003). Greene (2003) echoed this sentiment in stating that faith, spirituality, and a belief in something larger than oneself all help to facilitate the development of resilience.

Though not all forms of religiousness are related to positive mental health (Hill & Pargament, 2003), there is ample evidence that religion is generally a positive influence in the lives of subscribers. Religious beliefs and practices can comfort people who are fearful or anxious, increase one's sense of control, enhance feelings of security, and boost self-confidence. Koenig's (2009) meta-analysis of religion, spirituality, and mental health revealed that those who were more religious often experienced less anxiety than those who were less religious. Specifically, among 76 studies, 35 found significantly less anxiety among the more religious. 24 of the studies found no association, and 10 studies

reported greater anxiety among the religious. In a more recent study, Jansen et al. (2010) found that attendance at religious services was negatively correlated with both anxiety and depression.

Shared worship and spiritual community may help to engender a sense of unity which is empowering to people. Despite rapid advances in telecommunications, many (e.g., Seligman, 1990) argue that society is characterized by a diminished sense of connectedness and that spiritual or religious community may provide an important means of support (Hodges, 2002). This real or perceived connection to others, particularly to church-involved others, has been shown to enhance the well-being of adolescents (Mattis & Jagers, 2001). Religious support (from fellow church members or from clergy) has been associated with lower levels of depression, more positive affect, and increased life satisfaction (Hill & Pargament, 2008).

Religion and spirituality have been surprisingly robust variables in not only psychological literature but also in predicting physical health-related outcomes. A meta-analysis of the relationship between religious involvement and mortality (representing nearly 126,000 participants) found that people who scored higher on measures of religious involvement had 29% higher odds of having a longer life span than people lower in religious involvement (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000). Even simplistic religion and spirituality measures (such as denominational affiliation or church attendance) are significant predictors of health outcome variables (Koenig et al., 2001).

Spirituality versus Religion

Spirituality and religiosity are separate but related constructs. The lines between them are often muddled, challenging researchers as they attempt to parse out which religious-related qualities serve as protective factors for individuals against anxiety and depression. Typically, religiosity has been defined as believing in a higher power (e.g., God, Yahweh, etc.) as well as to specific behaviors such as praying and attending a religious institution (church, temple, mosque, etc.) Since religiosity often involves attendance at a particular worship site, it is often associated with specific religious traditions such as Christianity, Judaism, or Islam (Hodges, 2002).

Spirituality is a broader, more nebulous concept and encompasses beliefs and values which may or may not be related to affiliation with a religious institution and may or may not involve belief in a higher power. Spirituality encompasses a search for "meaning, unity, connectedness, transcendence, for the highest of human potential" (Pargament, 1996). Martin and Carlson (1988) define spirituality as "a process by which individuals recognize the importance of orienting their lives to something nonmaterial that is beyond or larger than themselves, so that there is an acknowledgment of and at least some dependence upon a higher power, or Spirit" (p. 59). Examples of spiritual strivings include praying and/or meditating, living simply, cultivating a humble attitude, attending church/temple functions, and discerning and following God's will.

There is considerable overlap between the terms "religious" and "spiritual." Both spiritual and religious individuals may pray. Both may attend religious services. An individual may express spirituality within a religious context. Since the constructs share

many overlaps, and psychological instruments (including the one to be used in this study) have items addressing each one (using the term "spiritual" and the term "religion"), both terms will be used throughout this manuscript.

African American Women and Religion as a Protective Factor Against Anxiety and Overeating

Religion and the Church in the African American Community

Religion and spirituality have consistently been identified as central components and defining characteristics within the lives of African Americans (Mattis & Jagers, 2001). Historians point out the central role religious beliefs had for African men and women who were brought to America as slaves. Their strong spiritual orientation was maintained and became an important resource through the period of slavery and beyond (Dunn & Dawes, 1999). This spiritual conviction as well as communal celebration in churches provided African Americans with an outlet in which to express pain, anger, and frustration with slavery as well as an avenue for maintaining hope for better times.

Religious involvement has been estimated as being higher within African American communities than in many other ethnic groups (Douglas et al., 2008; Mattis & Jagers, 2001) and continues to play a role in the promotion of individual physical and emotional health in those communities. In addition to the support one feels from being connected to a higher power, there is also tremendous value garnered from being a member of a church community. The church does not only offer a physical setting for

prayer and worship. It also affords African American members assistance, guidance, and support. The church has been described as a place of unity, community gathering, and aid in attaining social, economic, and educational goals (Frazier, Mintz, & Mobley, 2005). Church communities provide support systems, social outlets, educational instruction, leadership opportunities, and assistance in times of crisis (Dunn & Dawes, 1999). Finally, the African American church is also considered to be political in that it can inspire involvement with social justice movements and can mobilize members to vote (Mattis & Jagers, 2001).

Religion and Mental Health for African Americans

As was stated earlier in this paper, there is overwhelming support for a positive relationship between religious involvement and psychological adjustment, and African Americans are not an exception to this finding. Strong associations have been found between religiosity and various indicators of mental health and well-being among African Americans. Religion has been found to promote personal well-being and to mediate negative outcomes for African American adults. Specifically, in addition to the positive correlations between religiosity and positive well-being, religious variables are also linked to less tobacco use, decreased alcohol consumption, and lower rates of incarceration (Parson & Mikawa, 1991; as cited in Frazier et al., 2005).

In a 2008 study of 189 women, Douglas et al. found that among African American, spirituality was positively related to self-concept, active coping, positive attitudes towards parenting, and satisfaction with their social support. The authors also

found that religious factors were stronger predictors of life satisfaction for African Americans than for Whites.

Using a national sample of African American adults, Jang and Johnson (2004) found that religiously committed African Americans exhibited lower levels of distress than their less religious or nonreligious counterparts. Highly religious African Americans reported higher levels of sense of control and social support, which consequently reduces distress and anxiety.

Banerjee and Pyles (2004) conducted a study with low income African American women about the relevance (or lack thereof) of religion and/or spirituality in their lives. Through in-depth individual interviews, the authors discovered that spirituality was "a vital source of resilience for them" and helped them to cope with a multitude of life's adversities. One participant noted that her religion helped her self-esteem and helped her to feel that "nothing could destroy" her.

In two earlier studies, Ellison (1995) found more depressive symptoms among African Americans who reported no religious affiliation. Handal, Black-Lopez, and Moergen (1989) found that religiosity was negatively associated with symptoms of psychological distress among African American women. As is evidenced by the aforementioned studies, African Americans are clearly positively impacted by having a spiritual and/or religious practice.

The Spirituality of African American Women

African American women's spirituality is unique in that it is based on a strong sense of communalism reflected in kinship ties, emphasizing their relationship to others, as opposed to White, middle-class society's values of independence and self-sufficiency. Their spirituality involves a God who is intimately aware of the details of their lives and is concerned for them. Such concern by a loving God engenders self-esteem and optimism despite adversity (Banerjee & Pyles, 2004). This strong sense of support may help to alleviate feelings of anxiety in women and help to prevent overeating in order to deal with difficult emotions. This notion is echoed by Eugene (1995) who writes that psychological distress in African American women is mediated by the heightened spirituality of "churched African American women" because of the support and raised consciousness that these women enjoy. Women in the church benefit from (1) articulating suffering, (2) having a safe space in which to "act out," and (3) through receiving validation of their life experiences.

Often, suffering is expressed in faith communities through narratives or through songs such as spirituals and gospel music. Spirituals and gospel music disclose the African American battle against historical injustices including slavery and racism and their companions: sexism and classism. Spirituals and gospel music have come to represent a base for communication upon which African Americans have built a collective therapeutic perspective on their situation as oppressed people in America (Eugene, 1995).

In addition, spirituals and gospel music expresses suffering by Black women specifically. Singers such as Billie Holliday used the blues as a legitimate means by which to share the suffering of Black women in America. This articulation of suffering through music and speech seems to have a largely therapeutic effect. Such "collective catharsis" engenders heightened solidarity and a sense of cultural community.

Suffering of African American women may also be expressed through stories. This often occurs at prayer meetings but can also occur at worship services. Most often, prayer groups are comprised of women. Often, they recount stories of suffering in their lives and ask for prayers by other members to alleviate their suffering. Identification with Jesus as an oppressed one and as "a comforter in times of trouble" is generally strong in these groups.

It is possible that African American women who are religious enjoy better psychological health because of the cathartic effect of sharing their stories and receiving validation and support from fellow congregants or prayer group members. Knowing that one is not alone in suffering can provide sustenance and increase perseverance through difficulties. Besides feeling solidarity with others who share their faith, Mattis and Jagers (2001) found that religious salience was positively associated with psychological well-being among female African American college students. It appears that religion may affect well-being by providing concrete strategies for coping with distress and adversity and by providing real and/or perceived emotional and moral support.

Cultural Identity as Mediator of Anxiety/Overeating Problems in African Americans

Religion and spirituality are not the only factors that can positively impact anxiety (and ensuing eating problems) in African American women. Possessing a strong cultural identity has been shown to be a protective (mediating) factor against anxiety and depression in African American adolescents (e.g., Gaylord-Harden, Ragsdale, Mandara, Richards, & Petersen, 2007; Stevenson & Arrington, 2009) as well as in adults (e.g., Jones, Cross, & DeFour, 2007; Outten, Schmitt, Garcia, & Branscombe, 2009).

One of the mechanisms through which cultural identity acts as a buffer against anxiety and depression is through improving self-esteem. Strong cultural identity bolsters self-esteem among members of minority groups (Outten et al., 2009). Such an increase in self-esteem fortifies an individual's ability to cope with the pervasive devaluation and rejection that is associated with minority group status. This enriched self-esteem and coping capacity also protects against anxiety and depression.

Cultural Identity, Ethnic Identity, Racial Identity

Cultural identity is sometimes referred to as "ethnic identity" and is strongly linked to maintaining self-esteem in non-White ethnic groups. Ethnicity refers to membership in groups sharing a common social, cultural, and historical heritage (Helms & Talleyrand, 1997). It follows then that ethnic or cultural identity refers to one's sense of belonging to an ethnic group and to the part of one's thinking, perceptions, feelings,

and behavior that is due to ethnic group membership (Gaylord-Harden et al., 2007). Ethnic/cultural identity is often influenced by the cultural traditions, values, and beliefs unique to the ethnic group.

Race refers to one's physical appearance (phenotype) and to the assignment of advantageous or disadvantageous characteristics based upon their phenotype (Helms & Talleyrand, 1997). Racial identity as defined by Cross' (1971) theory of Nigrescence is the process by which persons of color develop a positive sense of self in the context of a society that discriminates against them. Cross, Parham, and Helms (1991) identified three important functions of Black racial identity including protection from psychological injury, giving meaning and grounding to one's sense of Blackness, and transcending challenging social interactions.

The terms "cultural identity," "ethnic identity," and "racial identity" are often used interchangeably in the literature. Essentially, the terms cultural identity and ethnic identity are considered to be synonymous. As was mentioned above, ethnic or cultural identity refers to one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behavior that is due to ethnic group membership (Gaylord-Harden et al., 2007). Though related to racial identity, the construct of ethnic/cultural identity is different. Race refers to groups who share physical attributes (e.g., Black) and ethnicity refers to shared values, customs, language, etc. (e.g., African American, Haitian) based on geography. The cultural identity model is multidimensional and includes the cultivation of traditions and beliefs of various non-White ethnic groups,

whereas the racial identity model focuses exclusively on engendering pride in one specific race (Johnson & Arbona, 2006).

The cultural identity and racial identity models are similar in that they are both known to help cultivate self-esteem in members of minority groups. Since this study refers to African American students (who can hail from various countries), the term cultural identity (also known as ethnic identity) will be utilized.

Cultural Identity and Self Esteem

Spending time with members of one's racial group (racial socialization) and expressing racial identity reinforces cultural values, enhances cultural identity, and promotes self-esteem in ways that buffer the deleterious effects of daily racial oppression (Cross, Parham & Helms, 1991). Ethnic identity and self-esteem show minor associations in children, but research suggests a convergence during adolescence as individuals become more aware of the social significance of their ethnicity and begin to encounter ethnic group barriers. Research has shown that there is a positive relationship between ethnic identity and self-esteem in African American adolescents. Specifically (and consistent with previous investigations), Outten and colleagues (2009) found that ethnic group identification was positively related to self-esteem.

These sentiments regarding the positive relationship between ethnic identity and self-esteem are echoed by Meeus, Iedamaa, Helsen, and Vollebergh (1999), who conducted a review of the literature on ego identity development and psychological well-

being and found that those in the "achieved" and "foreclosed" statuses had the highest levels of well-being. A person who has reached the "achieved" status of identity development has actively engaged in an exploration of his or her ethnicity and has committed to a specific definition of what it means to him or her. Persons who are in the "foreclosed" status of ethnic identity development have firmly committed to a definition of what their ethnicity means to them based on what influential figures (such as their parents) believe. However, the individual at this stage has not engaged in his or her own process of exploration as of yet (Phinney 1990; 1993). In sum, Meeus et al. found that two groups (out of four) had higher well-being than the others. Individuals who had done some amount of exploring their culture and ethnicity had high well-being, as well as those individuals who had committed to a definition of what their ethnicity meant to them despite not having engaged in their own personal exploration.

The Power of Membership: "We" instead of "Me"

Outten et al. (2009) wrote about the protective properties that identifying with one's disadvantaged group can have. Identifying with one's group in response to feelings of mistreatment is inversely related to depressive symptoms, psychological distress (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003), and low self-esteem. When individuals feel marginalized and devalued, identifying with the collective disadvantaged group can buffer the negative effects of unjust treatment. In addition, identifying with and investing more in the devalued group can have positive consequences for psychological well-being. Why is this?

First, according to social identity theory, this improved well-being may be due to feeling motivated to achieve a positive in-group identity based on favorable comparisons with relevant other groups (Tajfel, 1978).

Another factor is that working to protect the identity and interests of the (devalued) group often results in greater resiliency and this facilitates greater well-being. Greater resiliency is also nurtured through the self-efficacy that develops when one is identified with his or her cultural or racial group.

Additionally, conceptualizing oneself in terms of a shared group identity as opposed to a "lone wolf" who is being mistreated can foster higher tolerance for stressful circumstances. The cognitive appraisal process posits that when one is a member of a larger group, threats are evaluated as being less potent (Haslam, Jetten, O'Brien & Jacobs, 2004). In essence, the person feels less vulnerable when he or she feels like a member of a group with a shared identity.

Finally, this membership in a larger whole may engender great social support for one another. Shared cultural identities are a basis for trust and members of the same group are assumed to share similar values and social perspective. As a result, members trust one another over out-group individuals (Haslam et al., 2004). Relative to trusting others, in a 2007 study of 227 African American adolescents, Gaylord-Harden et al. found that cultural identity partially mediated the relation between social support and depression. Results suggested that ethnic identity functioned as an important link in how social support reduces internalizing symptoms in African American youth. The belief that one can receive social support from fellow in-group members who face the same

disadvantage may be especially important in alleviating the negative psychological consequences associated with racism.

Cultural Identity, Anxiety and Depression

In addition to the association between positive ethnic identity and self-esteem, negative ethnic identity is associated with higher levels of depression and anxiety in African American adolescents and college students (Roberts, Phinney, Masse, Chen, Roberts, & Romero, 1999). Similarly, Yip, Seaton, and Sellers (2006) found that African American college students with less developed cultural identities had more depressive symptoms. Specifically, Yip et al. examined cultural identity in 940 African Americans across three different groups: adolescents, college students, and adults. They found that college students with diffused cultural identities (in which they have neither explored the meaning of their ethnicity nor committed to a particular identity meaning) report higher levels of depressive symptoms than those with achieved cultural identities (meaning they have both explored their ethnicity and committed to a definition of what it means to them).

The college experience itself serves as a catalyst for ethnic identity development. For the first time, individuals may be presented with the option to participate in groups designed specifically for one racial or ethnic group (such as the Black Student Association). In addition, they may choose coursework which explores cultural roots or historical and current injustices which confront specific ethnic groups (such as African

American history) (Yip et al., 2006). The college years may provide a valuable opportunity for an African American student to elect to engage in the process of exploring his or her cultural identity. Conversely, African American students may be pushed into an examination of race and ethnicity if they are confronted by racial challenges that go along with being a member of a minority group on a predominantly White campus.

Since the college years are so ripe for exploring cultural identity, it is appropriate that the current study examines the role that cultural identity plays (if any) in mediating the relationship between anxiety and eating concerns in African American students.

Hypotheses

Based on the review of the literature presented in this manuscript, several hypotheses will be tested. First, the supposition that anxiety (the predictor variable) and overeating concerns (the criterion variable) are positively correlated will be tested. Subsequent to this, several other correlations will be analyzed along with two mediation models. The mediation models will test whether a mediator (in this case spirituality and cultural identity) can attenuate the impact that anxiety has on overeating concerns (See Figure 2-1 and Figure 2-2).

Figure 2-1.

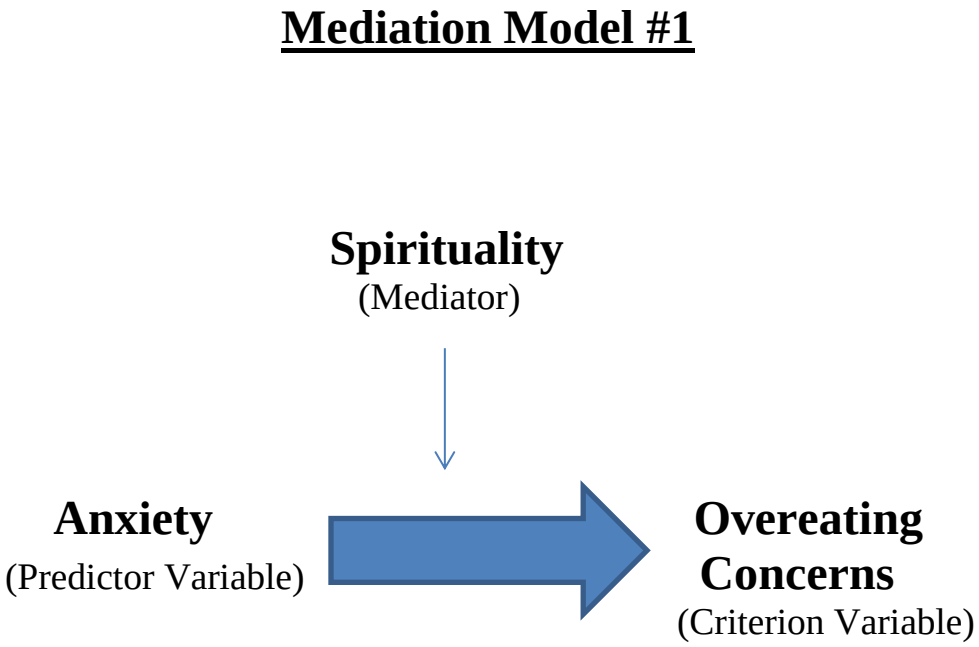
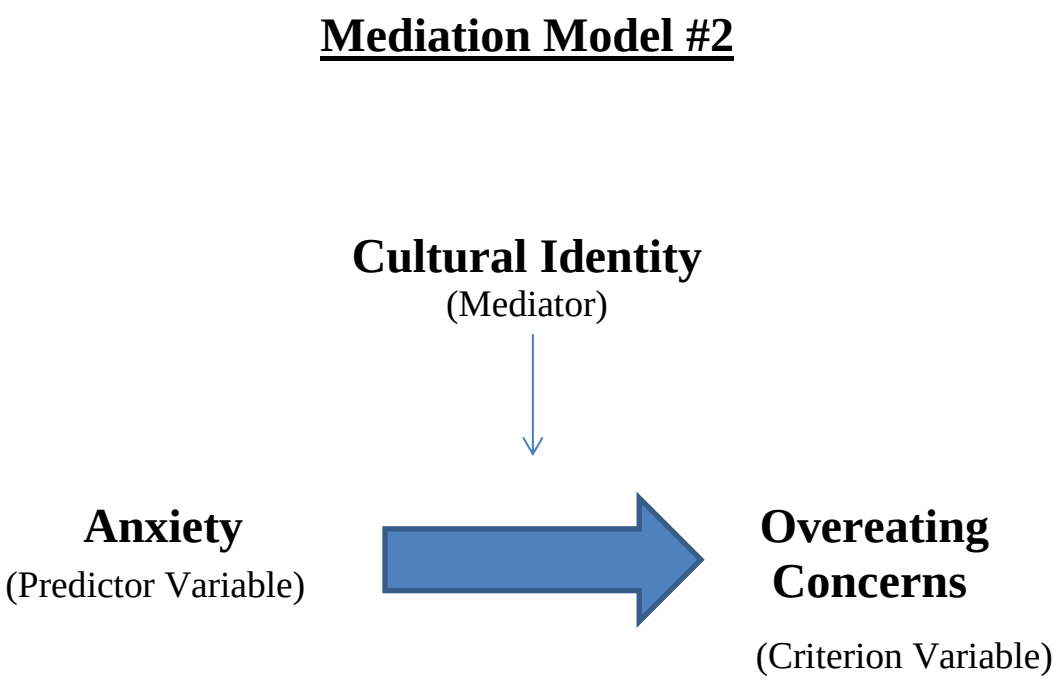

Mediation Model #1
Spirituality
(Mediator)
Anxiety
(Predictor Variable)
Overeating Concerns
(Criterion Variable)

Figure 2-2.


Mediation Model #2
Cultural Identity
(Mediator)
Anxiety
(Predictor Variable)
Overeating Concerns
(Criterion Variable)

The following is a list of hypotheses:

Hypothesis 1: There is a positive correlation between anxiety and overeating concerns.

Hypothesis 2: There is a negative correlation between spirituality and anxiety.

Hypothesis 3: There is a negative correlation between spirituality and overeating concerns.

Hypothesis 4: In the mediation model, spirituality will mediate the effect of anxiety on overeating concerns sufficiently so that the relationship between anxiety and eating concerns will be significantly (statistically) reduced.

Hypothesis 5: There is a negative correlation between cultural identity and anxiety.

Hypothesis 6: There is a negative correlation between cultural identity and overeating concerns.

Hypothesis 7: In this mediation model, cultural identity will mediate the effect of anxiety on overeating concerns adequately enough so that the relationship between anxiety and overeating concerns will be statistically significantly reduced.

Chapter 3

METHODS

Participants

The researcher utilized the data set from the pilot study of the Counseling Center Assessment of Psychological Symptoms-70 (CCAPS-70) conducted by the Center for Collegiate Mental Health (CCMH).

The sample was national in scope and was composed of college students who sought services at university counseling centers from across the country during the Fall 2008 semester. A total of 27,616 students participated and 66 university counseling centers were represented. Most of the students were women (65%); 35% were men. In terms of ethnicity, 8% of participants were African American, 70% were European American, 6% were Asian American, 6% were Latino, 3% were multi-ethnic, 5% were of some other ethnicity, and 2% did not report ethnicity. International students accounted for 4% of the sample and represented 169 countries. These International participants will not be included in the sample utilized for the current study.

The mean age of participants was 22.7 years. In terms of university/college years represented, 18% were first year students, 19% were sophomores, 22% were juniors, 23% were seniors, and 15% were graduate students; 3% did not report their class standing. Most students in the sample identified as heterosexual (89%); 2% identified as gay, 1% as lesbian, 3% bisexual, 1% reported that they were questioning their sexual orientation, and 3% opted not to designate their sexual orientation. Regarding religious orientation,

the majority of participants identified as Christian (53%); 13% of students endorsed "no religious preference," 10% identified themselves as agnostic, 5% as atheist, 3% as Jewish, and 1% each as Muslim, Hindu and Buddhist.

This study focused on African American, female, non-international students. Of the 27, 616 students in the CCMH data set, 8% were African Americans. Specifically, there were 827 African American, female students in the sample. 19 of these women were international students and so they were eliminated from the sample. That left a group of 808 individuals. However, 35 of these women left international student status blank. Therefore, these 35 individuals were omitted resulting in a final sample size of 773 individuals (n= 773).

Measures

Two instruments were utilized during the investigation: the Counseling Center Assessment of Psychological Symptoms-70 (CCAPS-70) and the Standardized Data Set (SDS) questionnaire.

The Counseling Center Assessment of Psychological Symptoms-70 (herein referred to as "CCAPS-70") is a 70-item questionnaire that was developed in order to assess mental health concerns of college students. Created by a research team at the University of Michigan's counseling center, the CCAPS-70 is designed to assess a student's mental health at intake and to measure progress during the treatment period at the college counseling center. The CCAPS-70 consists of nine subscales that measure Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, Substance Use,

Family of Origin issues, Academic Distress, Hostility, and Spirituality. Respondents are asked to indicate how well the items describe them during the previous two weeks. The instrument uses a 5-point Likert-type scale ranging from 0 *("Not at all")* to 4 *("Extremely well").* In addition to the aforementioned nine subscales, the CCAPS-70 includes five freestanding items that relate to dissociative symptoms, cultural/ethnic identity, violent thoughts, and history of abuse.

The Standardized Data Set (SDS) was administered to participants in order to gather demographic information as well as mental health history. Unlike the CCAPS-70, the SDS was only administered once (at intake). It contains items that inquire about participants' gender, sexual orientation, and race as well as assessing prior use of psychotropic medication and suicide attempts.

The CCAPS-70 was developed specifically for a college student population and has been tested and normed on them. Multiple studies have lent support for the factor structure and reliability for the nine CCAPS-70 subscales with internal consistency reliability coefficients ranging from .80 to .93. Convergent validity was evidenced as the students who received diagnoses consistent with clinical concerns in academic role, eating issues, general anxiety, or depression also had elevated scores on relevant CCAPS subscales (Soet & Sevig, 2006).

With regard to discriminant validity, Soet and Sevig (2006) point out that there was no significant relationship between clients' diagnosis index in the area of social role anxiety and clients' scores on the Academic Distress subscale of CCAPS (r=.059, p=.359).

In addition, internal consistency was examined by identity group (race/ethnicity, gender, international student status) and was found to be satisfactory (greater than .75) for all groups. The factor structure of the CCAPS-70 was supported by both exploratory and confirmatory factor analyses (Soet & Sevig, 2006).

Procedure

Students who presented for counseling at university counseling centers were asked to complete the measures at their intake appointment. They were given the CCAPS and SDS, as well as an informed consent form.

Chapter 4

DATA ANALYSES

Preliminary Analyses

Means, standard deviations, and ranges were assessed for all primary variables (anxiety, overeating concerns, spirituality, and cultural identity; see Table 1). For the African American women sampled, the average score on the Anxiety scale was 1.55 (SD=.9). This mean score falls below the theoretical midpoint of the 5-point Likert scale used in the CCAPS-70 and was close to the national norm on this subscale among students seeking services at college counseling centers (Center for the Study of Collegiate Mental Health, 2010).

The criterion variable in the study was overeating concerns. Three items from the original Eating Concerns subscale of the CCAPS-70 (item numbers 6, 16 and 29) comprised the scale used in this study. These three items were chosen because they focused on the issue of overeating (e.g., "I feel out of control when I eat") as opposed to general dissatisfaction with body size. These three items were found to be valid as indicators of concern about overeating in subsequent versions of the CCAPS. The average score on these three items was .95 with a standard deviation of 1.20. The mean score for overeating concerns of .95 falls between the lowest anchor of the Likert scale used on the CCAPS-70 (zero) but closer to the second anchor (one). Zero is defined as

"Not at all like me" evidencing a rather low level of overeating concerns among the sample of women in this study.

Means, standard deviations, and ranges were assessed for the two mediating variables of spirituality and cultural identity (See Table 1). The average Spirituality scale score was 1.63 with a standard deviation of 1.29. The average Cultural Identity item score was 1.68 and the standard deviation was 1.39. Both scores fell below the theoretical midpoint of 2.5 indicating that for the women in the study, spirituality and cultural identity were not integral components of their identities.

Primary Analyses

The first hypothesis was that Anxiety would be positively correlated with Overeating Concerns. To test this hypothesis, a Pearson correlation coefficient was computed. The hypothesis was supported ($r = .28$, $p < .01$) as the resulting correlation was statistically significant; Anxiety was positively correlated with Overeating Concerns and explained about 9% of the variance.

The second hypothesis was that there would be a negative correlation between Spirituality and Anxiety. To test this hypothesis, a Pearson product correlation coefficient was computed. This resulted in a statistically significant correlation providing some support for the idea that spirituality helps to reduce anxiety ($r = .06$, $p < .05$). However, the magnitude of the correlation was so small (explaining less than 1% of the variance) that it is a negligible finding. (Note: The Spirituality scale was reverse scored.

Therefore, an inverse relationship between the variables exists despite the positive direction of the correlation).

The third hypothesis was that there would be a negative correlation between Spirituality and Overeating Concerns. A Pearson correlation coefficient was computed for this. Though the results were statistically significant ($r = .10$, $p < .01$), they explained just 1% of the variance and were not meaningful.

The fourth hypothesis posited a mediation model in which Spirituality would mediate the effect of Anxiety on Overeating Concerns so that the relationship between the two would be significantly reduced. A multiple regression was conducted to test the mediation model and results indicated that Spirituality does not significantly mediate this relationship. Although the multiple regression coefficient was statistically significant ($R = .27$, $p< .05$), the magnitude of the relationship between Anxiety and Overeating Concerns that was discussed in relation to the first hypothesis ($r = .28$) was essentially unchanged when Spirituality was added to the regression equation. This makes sense in light of the small correlations between Spirituality and both Anxiety ($r = .06$) and Overeating Concerns ($r = .10$).

The fifth hypothesis proposed a negative correlation between Cultural Identity and Anxiety. A Pearson correlation yielded non-significant findings ($r = .02$, $p > .05$). The sixth hypothesis proposed a negative correlation between cultural identity and eating concerns. This also yielded non-significant findings ($r =.05$, $p > .05$).

Hypothesis seven was a proposed mediation model in which Cultural Identity would mediate the effect of Anxiety on Overeating Concerns so that the relationship between Anxiety and Overeating Concerns would be significantly reduced. Since

hypotheses five and six were not supported, hypothesis seven could not be, and was not, statistically significant (i.e., there was no relationship between the Anxiety and Overeating Concerns to be mediated).

Additional Analyses

Several additional analyses were conducted and in each case the findings from the primary analyses remained unchanged. The first additional analysis involved using a composite of Spirituality and Cultural Identity as a combined mediator of the relationship between Anxiety and Overeating Concerns. Though it seemed plausible that combining the two mediators would yield an effect, it still failed to exert a significant change in the relationship between Anxiety and Overeating Concerns.

A second additional set of analyses was run with only those individuals who endorsed body dissatisfaction (CCAPS items # 23 and #26); again, the results were not different from those found for the sample as a whole. A final additional analysis involved using a single item from the SDS related to "the importance of religion" in individuals' lives and also resulted in findings similar to those reported earlier. Thus, when primary variables were operationalized in a variety of ways, findings were confirmed.

Table 4-1.

Means, Standard Deviations, and Ranges for Primary Variables

Variables	M	SD	Range	Possible Range
Anxiety	1.55	.91	0 to 4	0 to 4
Overeating Concerns	.95	1.20	0 to 4	0 to 4
Spirituality	1.63	1.29	0 to 4	0 to 4
Cultural Identity	1.68	1.39	0 to 4	0 to 4

Table 4- 2.

Correlations among Variables

Variable	1	2	3	4
1. Anxiety	-	.28**	.06*	.02
2. Overeating Concerns		-	.10**	.05
3. Spirituality			-	.28***
4. Cultural Identity				-

*p ≤ .05

** p ≤ .01

*** p ≤ .001

Chapter 5

CONCLUSION

In this final chapter, six areas will be explored. (a) First, (and perhaps most importantly), the results of the study will be discussed. The hypotheses will be reiterated along with a discussion of the empirical support for each. (b) Following this, the current results will be compared to previous research in order to ascertain where current findings fit in the body of literature concerning anxiety, overeating, spirituality/religion, and cultural identity for African American women. (c) Next, the implications of this research for psychological practice will be discussed. (d) Limitations of the study will be highlighted and (e) potential areas of future research will be identified. (f) Finally, the study will be summarized and the paper concluded.

Results of Hypotheses

This study involved an examination of anxiety experienced by African American women students. Anxiety in this population of university students is often related to the racism, sexism, and classism that they experience. One common response to anxiety is to seek solace in food. Consequently, there is a risk of overeating as a response to the stress and anxiety experienced by this group of students. This notion was supported empirically in the current study; the hypothesis regarding the positive relationship between anxiety

and overeating concerns was substantiated. Results indicated that anxiety was moderately correlated with eating concerns (explaining about 9% of the variance); women who endorsed higher anxiety levels also reported experiencing more eating concerns. This is in alignment with previous research (e.g., Ivezaj et al., 2009; Mitchell & Mazzeo, 2004) which indicates that women may turn to food as a source of comfort when experiencing anxious feelings.

As was explicated earlier in this manuscript, anxiety is often a byproduct of experiencing racism, sexism, or classism. Of these three, race-related stress is especially germane to high anxiety in African American women (Banks et al., 2006; Gaylord-Harden, 2009; Sellers et al., 2006). In their 2009 study of binge eating and anxiety among college students, Ivezaj et al. (2009) discovered that African American participants experienced higher levels of anxiety than their White counterparts. The consistent vigilance that African Americans speak about takes an emotional toll and food has been called a "reliable" and "comforting" way to deal with such distress. Bulik et al.'s (2002) study of binge eating found that women who engaged in episodes of binge eating had higher anxiety and depression than those who did not binge eat, again evidencing the tendency for women to deal with anxiety through food.

Though this study did find a positive correlation between anxiety and overeating concerns, it is possible that the model operates in the reverse direction; namely that overeating concerns cause anxiety. This anxiety may be about one's physical appearance, health, or may relate to shame. Future studies could explore the potential for overeating to cause increased anxiety (e.g., through longitudinal research). Additionally, it is

possible that a third variable, such as a woman's physical health history, is responsible for the relationship that was observed between anxiety and concerns about overeating.

The author also hypothesized that individuals who are more spiritual or religious would experience less anxiety than those who are less spiritual (Hypothesis 2). This hypothesis rested on the assumption that a woman's spiritual or religious life would buffer her from the effects of anxiety. Despite the previous empirical as well as anecdotal data regarding the positive effects that spirituality and religion exert on anxiety, the hypothesis that there would be a negative relationship between the two resulted in a very small correlation (explaining less than 1% of the variance) and is not meaningful. For African American college students utilizing college counseling centers, spirituality did not help to ease their anxiety. It is surprising that the results are not more statistically significant because there is a great deal of support in the literature linking spirituality and religion with resilience. There are specific data regarding the buffering effects a spiritual life can exert on anxiety (e.g. Jansen et al., 2010; Koenig, 2009; Smith et al., 2003; Whitley, 2012) though admittedly, only a portion of the studies involve college students. Furthermore, religious involvement has been estimated as being higher within African American communities than in other racial or ethnic groups (Douglas et al., 2008) and has consistently been identified as a central component of their lives and in their coping repertoire (e.g., Banerjee et al., Frazier et al., 2005) adding support to the notion that African American students' anxiety would be eased by spirituality.

Despite such prior research, the current study found that spirituality and religion do not in fact help assuage anxiety for this population. There may be alternative explanations for the weak correlation between anxiety and religion. Several potential

factors will be explored below including: the age of participants, notions about God, type of religious orientation (extrinsic versus intrinsic), sample limitations, and potential weakness of the spirituality assessment used.

Perhaps the lack of relationship between anxiety and religion is due to the age of the participants in the current study. College students tend to be less religious and less spiritual than middle aged and older adults (Bryant & Astin, 2008; Turner-Musa & Lipscomb, 2007). Though university students may consider themselves to be spiritual or religious, generally, their spiritual lives are less active than those of non-students. A 2010 study of college students by Stoppa and Lefkowitz illustrated this. They found that there was a general decline in the salience of religious values relative to other values during the college years. They also discovered a significant decline in behavioral aspects of religiosity among college students (such as decreased attendance at weekly services). Students may have less time to devote to a spiritual or religious practice than non-students or they may simply be exercising their right to abstain from regular worship. It is common for young adults who are moving through the stages of identity development to forgo rituals from their youth and to question formerly held beliefs (Turner-Musa & Lipscomb, 2007).

At times, spirituality and religiousness are associated with greater anxiety instead of with decreased anxiety. This may help to explain why the hypothesis regarding the positive effect of religion was not supported. Individuals may feel that their distress or anxiety is a result of God punishing them for a prior transgression. In a 2005 study of women with cancer, women who felt that they had been abandoned by God, by their faith community, or were being punished by God had significantly higher anxiety (Boscaglia,

Clarke & Jobling, 2005) than those who did not attribute their diagnosis to a punishment. If students in the current study felt that their problems were some sort of punishment delivered by God, then it makes sense that their religion or spirituality would not ease the anxiety they experienced.

Alternatively, perhaps there was no effect to speak of regarding religion/spirituality and anxiety because many in the sample were more extrinsically religious rather than intrinsically religious. It has been suggested (e.g., Possel, Martin, Garber, Banister & Pickering, 2011) that an intrinsic orientation is associated with better mental health than an extrinsic orientation. Extrinsic religious activities include outward behaviors such as church attendance as opposed to internal acts such as prayer or meditation. One study found that adults who were more extrinsically religious were more depressed (Possel, Martin, Garber, Banister, & Pickering, 2011). Though such a correlation between anxiety and extrinsic religiousness has not been found, it is possible that it exists.

It is plausible that there was such a small correlation between spirituality/religion and anxiety because of the clinical nature of the sample. The participants in the sample were students who presented for counseling at university counseling centers. Perhaps they were generally less religious/spiritual than students who did not present for counseling treatment. It is conceivable that students who are more spiritually or religiously inclined enjoy the protective factors of spirituality/religion and/or the social support of a religious community. Consequently, such students may not feel the need to seek out counseling services as much as non-religiously affiliated students. Therefore, the

students included in this study may have been less spiritually/religiously inclined and therefore, their anxiety would not have been ameliorated by these protective mechanisms.

Finally, it is possible that the weak correlation between anxiety and spirituality was related to the spirituality measure itself. The religion/spirituality subscale was eliminated from subsequent versions of the CCAPS (CCAPS-62) because it evidenced such low correlations among the other variables. Perhaps there are better ways to measure how spirituality and or religion effectively boost resilience.

The third hypothesis was that there would be a negative correlation between spirituality and eating concerns. The correlation yielded a small effect size and proved to be statistically significant but negligible (explaining only 1% of the variance). According to these findings, maintaining a spiritual or religious life does not help individuals who have concerns about overeating.

There is not a significant body of literature related to the issue of spirituality and overeating. However, given the numerous health benefits related to having a personal spiritual or religious life (higher well-being, decreased depression, anxiety etc.), the author reasoned that a spiritual or religious affiliation would also exert a positive influence on overeating. This writer's hypothesis was also influenced by the plethora of research concerning the benefits of maintaining a spiritual life for those who overuse drugs or alcohol. Numerous studies (e.g. Button, Hewett, Rhee, Corley, & Stallings, 2010; Greene & Nguyen, 2012) extol the benefits of spiritual or religious beliefs in (1) efforts to become clean and sober and in (2) sustaining recovery. Some substance abuse recovery programs (e.g. twelve-step programs) even encourage participants to cultivate a relationship with a higher power to assist them in their efforts to abstain from

alcohol/drugs. However, the results of the current study indicate that increased religious or spiritual affiliations do not positively influence African American women who overeat.

The fourth hypothesis posited a mediation model in which religion/spirituality would mediate the effect of anxiety on eating concerns so that the relationship between the two would be significantly reduced. Since there was such a small relationship between spirituality and both the predictor and criterion variables (anxiety and overeating concerns), it could not mediate the relationship between the two.

The fifth and sixth hypotheses concerned the cultural identity variable. Hypothesis 5 proposed a negative correlation between cultural identity and anxiety. A Pearson correlation yielded non-significant findings. This was somewhat surprising given the increasing number of studies that indicate cultural identity is a protective factor against anxiety associated with experienced racism. There is a growing body of literature which indicates that individuals who cultivate stronger connections with their referent group and invest in their own cultural distinctiveness tend to have higher self-esteem. This self-esteem acts as a buffer against the deleterious effects of racism (e.g., Gaylord-Harden et al., 2007; Johnson & Arbona, 2006; Outten et al., 2009). Perhaps students higher in cultural identity enjoy better self-esteem but the construct does not, in fact, alleviate anxiety. The anxiety experienced by African American women students (racism-related or not) is not influenced by one's cultural identity.

Hypothesis 6 proposed a negative correlation between cultural identity and eating concerns. These findings were not significant. Possessing a stronger cultural identity had no effect on eating concerns. There is not a body of scholarly literature related to these two variables; however this researcher theorized that since the cultural identity construct

is gaining attention as a source of resilience, it may help reduce eating concerns. This was not the case in the current study. Cultural identity did not help to alleviate anxiety or eating concerns in African American students.

Hypothesis 7 proposed a mediation model in which cultural identity would mitigate the effect of anxiety on eating concerns so that the relationship between anxiety and eating concerns would be significantly reduced. As was reported in chapter four, since cultural identity was not inversely related with either anxiety or eating concerns, hypothesis seven could not be supported.

To summarize, one hypothesis resulted in a meaningful correlation: anxiety was positively related to overeating concerns in this sample of African American women students. However, neither spirituality nor cultural identity were shown to have a significant effect on anxiety or overeating.

Implications for Clinicians

When African American women experience anxiety (often associated with racism), are they more inclined to overeat? Can an active spiritual or religious life help to ease anxiety for African American women? Can such practices attenuate tendencies to overeat? Alternatively, can a strong cultural identity help to fortify an African American woman against stress and anxiety? Can it help prevent overeating? One hypothesis in the current study was supported: anxiety and overeating concerns are (positively) related in African American college women. As such, when clinicians consider ways to effectively help African American clients who are experiencing anxiety, several issues

should be considered. First, practitioners may want to ascertain if the client is dealing with her anxiety through overeating. Since anxiety and overeating concerns are positively correlated (in the current study as well as in the literature), and obesity is such a widespread health problem for African American females, it is logical to explore this issue with a woman struggling with anxiety. There are a variety of therapeutic approaches a clinician may employ in an effort to improve anxiety including psychodynamic therapy, cognitive behavioral therapy, biofeedback, mindfulness meditation, or incorporating other treatment modalities that may be beneficial.

The study failed to indicate conclusively that either spirituality or cultural identity can ease anxiety and resultant overeating for African American college women. There exists a plethora of literature extolling the physical and mental health benefits reaped from a spiritual or religious practice. Though the current investigation did not add to the body of literature endorsing the benefits of spirituality or cultural identity, it is possible that these variables may be useful for individuals other than anxious college students and future research could focus on that.

Therapy with African American Women

Psychologists encounter clients with myriad challenges including anxiety. This study has highlighted the fact that for African American women, their anxiety is frequently linked with experiences of racism. Therefore, it is prudent for practitioners to be familiar with the emotional ramifications of experienced racism and be versed in ways to work this sensitive and pervasive issue. Clinicians should not merely be aware of the reality of racism in the lives of African American clients, but should invite clients to

speak about it. Bryant-Davis and Ocampo (2005) point out the potential for racist incidents to not only cause anxiety, but to engender traumatic responses. It is important for clinicians to acknowledge the potentially traumatizing impact of racist experiences, to assess for this, and to use appropriate treatment modalities.

One specific treatment approach which has been useful with students who are confronted with racism is problem-solving coping. Problem-solving coping helps to increase one's perceived sense of control which in turn increases adjustment. In a study of 114 African American students experiencing racism, researchers found that when participants encountered discrimination and used avoidant coping (such as sleeping more or watching more TV), they experienced more symptoms of depression and endorsed lower satisfaction with life. However, when a more active, problem-solving approach was employed, life satisfaction was higher and stress was lower (Barnes et al., 2005). Therefore, when working with African American clients struggling with experiences of racism, it may be useful for clinicians to discourage avoidant coping strategies and to encourage problem-solving styles of coping. Problem-solving strategies may be identified and even practiced in therapy. They might include defining the problem, generating alternatives to responding in anger, selecting strategies and tactics, and taking action (Barnes et al., 2005).

Workshops and/or support groups on campus may also prove to be beneficial to African American students. Both venues offer African American women opportunities to discuss experiences of racism, sexism, and/or classism and to promote a range of coping strategies. Such workshops or groups may enhance participants' abilities to cope (using pro-social behaviors) with the effects of racism (Thomas et al., 2008). Support groups

for African American women on predominantly White campuses may help improve students' comfort in the environment as well as helping to establish social supports. In addition, the existence of support groups is associated with academic retention of African American students on predominantly White campuses (Lukas & Berkel, 2005).

Using Religion and Spirituality in Therapy

As was acknowledged above, this study failed to support the notion that spirituality or religion helps to ease anxiety or overeating concerns in African American college women. However, the studies and meta-analytic reviews that corroborate the salutary effects a spiritual life can imbue lead this researcher to believe that it does benefit some people. Therefore, despite the dismal results of this query, this researcher feels that it is worthwhile to mention ways that practitioners can capitalize on this source of resilience when clients and psychologists deem that it is appropriate. In fact, for clients for whom spirituality or religion is an important part of their lives, it seems a disservice to exclude the issue from the therapy room. Furthermore, to do so is demonstrating a lack of cultural competence.

A spiritual or religious life may aid clients in making meaning of past or present circumstances, may help in enduring suffering, may increase hope and healing, and may provide access to a community of people who can offer emotional and social support (Whitley, 2012). In addition to exploring spirituality and religion as potential resources for clients, it is also useful to explore these areas in therapy in order to better understand a client's worldview. Exploring a client's spiritual and/or religious life provides the therapist with a means of understanding how she/he makes meaning of her or his life and

is an important variable to consider in the therapy room along with gender, race, ethnicity, culture, and socioeconomic status (Dunn, 1999). Religion may be an especially salient variable for African Americans who have historically depended on it to cope with adversity and oppression and to maintain a sense of meaning in their lives (Dunn, 1999). Psychologists may consider aiding African American women to access spiritual/religious resources in order to cope with anxiety and/or racism as these have been found to be successful strategies for other concerns (Utsey et al., 2000a).

Though religion and spirituality are often positive and healthy influences in people's lives, they can also have destructive effects. For example, they may engender harmful blame, criticism, and judgment of self and others. Therapists should assess how the religious and spiritual experiences of clients interact with their presenting problems as well as with their overall well-being.

Cultural Identity and Therapy

In this investigation, cultural identity did not help to ease anxiety or eating concerns in African American women, indicating that it is not a source of resilience relative to these problems. However, the construct of cultural identity may have the potential to help individual clients with other challenges (e.g., depression, loneliness) and it seems wise for psychologists be aware of this. If client and clinician agree that investigating the buffering effects of cultural identity may be useful, practitioners could explore cultural identity and brainstorm ways that it could be enhanced. College counseling center professionals should educate themselves and learn about resources on campus for students of color. Specifically, if students are unaware of organizations or

venues in which to connect with other students of color, clinicians could help them to access these groups. This may be especially useful for minority status students who are feeling isolated or distant from people of similar cultural backgrounds. Furthermore, if students are unaware of the notion of racial identity development, clinicians can help them to learn about this process.

Research Implications

This study had mixed results. As predicted, anxiety was positively correlated with overeating concerns in African American college women. As was written earlier in this paper, there is a propensity to overeat and a resultant widespread obesity problem in the African American female population. Given the myriad negative consequences of obesity (heart disease, diabetes, etc.), it seems crucial for both mental health practitioners as well as those in the medical community to address some of the antecedents of binge eating or overeating in general. If anxiety is a precursor to overeating, then clinicians as well as researchers should address ways that African American women can manage it that do not involve food as a panacea.

The other hypotheses in the study were not as supported as the anxiety/overeating correlation. A religious or spiritual practice did not have the hypothesized effect on mitigating anxiety or overeating concerns for African American women. Possessing a strong cultural identity also failed to mediate anxiety or overeating concerns experienced by this group of women. Future research should involve a community sample as well as a more thorough assessment of the mediators (religion/spirituality and cultural identity) as well as the criterion variable (overeating

concerns). Assessing the mediators and criterion variable with more comprehensive scales such as the *Spiritual Involvement and Beliefs Scale* (SIBS; Hatch, Burg, Naberhaus, & Hellmich, 1998), the *Spiritual Transcendence Scale* (STS; Piedmont, 1999), the *Multigroup Ethnic Identity Measure* (MEIM; Phinney, 1992) and the *Emotional Eating Scale* (EES; Arnow, Kenardy & Agras, 1995) may yield different findings. Finally, perhaps future research should incorporate interviews as doing so would yield a much richer pool of data.

Limitations and Future Research

The current study was limited in several ways. Potential confounds stem from the sample chosen (a convenience sample of college students), sample composition (individuals who were seeking services at college counseling centers) and with the assessments utilized. First, though the investigation benefited from a large, national sample, it was not randomly selected. Instead, the sample consisted of students who presented for services at college counseling centers. Secondly, the study only surveyed college students. This population is a typical convenience sample used in research and is not generalizable across the population at large.

Additionally, college students may be particularly non-religious or non-spiritual, which may have limited the findings of the study. As was mentioned earlier in this chapter, adolescents and college students typically undergo identity development during these years and question previously unchallenged beliefs (including their religious or spiritual traditions). For students who are living away from home, it may the first opportunity they have to choose whether or not they will attend religious services. They

may elect not to do so during this phase of their lives. Given the questions raised during the college years as well as the newfound liberties many students enjoy, religious and/or spiritual affiliations may be particularly weak during this stage. Future similar research should focus on a community sample. This researcher suspects that involving African American adults from the community in research concerning anxiety, spirituality and cultural identity would yield stronger findings. Specifically, adults are likely to possess a more developed religious or spiritual life. In addition, African American adults (as opposed to students) are more likely to have already engaged in an exploration of their ethnicity and to have achieved a cultural identity. By surveying adults as opposed to college students, there may be higher mean scores on both mediators (spirituality/religion and cultural identity) which may help to decrease anxiety and overeating (and result in more significant findings).

Furthermore, the scales used to measure the variables in question were relatively brief. Both Spirituality and Overeating Concerns were assessed using three items for each. Cultural Identity was assessed with only one item. Single item measures of constructs tend to have low reliability (often about .25) thus limiting the validity of the data garnered. If a full scale had been employed to measure spirituality/religion (such as the *Spiritual Involvement and Beliefs Scale*), the researcher would have gained a more complete picture of the individual's spiritual practice/beliefs as well as religion's relevance in his or her life. In future research, using full scales to assess spirituality would yield more information. Moreover, incorporating qualitative methods such as interviews would yield a very rich pool of data. Such interviews could include asking individuals about their experiences with racism, sexism, and classism and how such

experiences affect them. Inquiries should be made into feelings of anxiety, how women cope with these feelings, and specifically if overeating is a problem for them. Strategies that participants use to cope with challenges should be explored. If religion, spirituality, and/or cultural identity are identified as strengths, these areas could be fully explored with the interviewer in an effort to understand the salutary nuances of each. This would add to the literature relevant to improving the mental and physical health of a frequently overlooked group: that of African American women.

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Mobile Therapist; State College, PA; October 2007-June 2008

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