Body Dissatisfaction of Female Eastern-European Immigrants in the United States

Sviatlana S. Mitsina
Pacific University

Recommended Citation

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Body Dissatisfaction of Female Eastern-European Immigrants in the United States

Abstract
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BODY DISSATISFACTION OF FEMALE EASTERN-EUROPEAN IMMIGRANTS IN THE UNITED STATES

A THESIS
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
HILLSBORO, OREGON

BY
SVIATLANA S. MITSINA

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

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APPROVED:
Abstract

This study explored the relationship between body dissatisfaction of 69 female Eastern-European immigrants in the United States and the ethnicity of their romantic partner (Eastern-European vs. non Eastern-European). Results showed no difference between body dissatisfaction of women with Eastern-European partners and women with non Eastern-European partners. Significant correlations were also found between disordered eating behaviors and acculturation; between relationship satisfaction and body dissatisfaction, disordered eating, and BMI; and between acculturation and partner ethnicity. It was concluded that factors other than partner ethnicity contribute to body dissatisfaction of female Eastern-European immigrants in the United States. These factors may include acculturation, BMI and relationship satisfaction. Future studies should further investigate of the relationship between acculturation and disordered eating.

Keywords: Disordered eating, Eastern-Europe, Eastern-European Immigrants, Body Dissatisfaction, Body Image, Partner Ethnicity
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Body Dissatisfaction of Female Eastern-European Immigrants in the United States

Eating disorders have the highest mortality rate of all psychological disorders (Millar et al, 2005). In a multiple-sample study of patients with anorexia nervosa, Steinhausen (2002) found mortality rates between 1.36% and 17.8% as a direct result of this disorder, and 20.8% of participants never recovered. Furthermore, 50% of people with bulimia nervosa will not recover, and only 30% will experience at least four months of symptom remission (Bohon et al, 2009). There are currently approximately 10,000,000 people diagnosed with eating disorders in the United States, most of them women (Swanson et al., 2011). Body dissatisfaction is one of the primary features of eating disorders (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004) and is defined as a “negative subjective evaluations of one’s physical body” (Stice & Shaw, 2002).

Two factors that have been shown to affect body dissatisfaction are culture and ethnicity (Jaeger et al., 2002), and many studies examining this relationship have been conducted (DeBraganza & Hausenblas, 2010; Li-Wey Soh et al, 2008; Phan & Tylka, 2006; Wardle, Haase, & Steptoe, 2006). However, very few of these studies focus on Eastern-European female immigrants to the U.S. It is important to understand the issues that Eastern-European migrant women face, as research shows that immigration can be a risk factor for developing body dissatisfaction (Bulik, 1987). Furthermore, the relationship between partner ethnicity and body dissatisfaction has not been explored. This study will investigate the potential relationship between partner ethnicity (North American vs. Eastern European) and body satisfaction of female Eastern European immigrants in the United States. The null hypothesis of this study is that there will be no difference in body dissatisfaction and disordered eating behaviors of women whose partners are Eastern-European and women whose partners are not Eastern-European.

The prototypical eating disorder case has been a young, White, middle- or upper-class
woman, who lives in Europe or North America. This may be due in part to the tradition of defining eating disorders around White girls and women, and relying on patient samples which tend to be White, more educated, and of higher socioeconomic status. Studies have shown that eating disorders are also commonly found across the globe - across cultures and ethnicities. In order to gain a better understanding of risk factors for developing eating disorders more research involving the underrepresented populations needs to be carried out (Striegel-Moore & Bulik, 2007). A risk factor is defined as a characteristic or experience (e.g., growing up in a culture that values extreme thinness) that happens before an outcome of interest (e.g., an eating disorder) and that, “if present, is associated with an increase in the probability (risk) of a particular outcome over the base rate of the outcome in the general (unexposed) population” (Kazdin, Kraemer, Kessler, Kupfer, & Offord, 1997, p.377).

Sociocultural models of eating disorder etiology suggest that exposure to the Western culture, to its value of extreme thinness, and to its objectification of the female body represent a risk factor for developing an eating disorder (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Thompson & Stice, 2001). The following pathway of eating disorder development is described: exposure to the thin ideal; internalization of the ideal; and experience of a discrepancy between the self and the ideal. This sense of discrepancy may lead to body dissatisfaction and dietary restraint or restriction. In some people, restraint and/or restriction may lead to overeating, which increases body dissatisfaction and causes further restraint and/or purging behaviors (Polivy & Herman, 1985; Striegel-Moore et al., 1986). Additionally, Western culture’s objectification of the female body contributes to eating disorder risk by teaching girls and women that their value is appraised by their appearance, further reinforcing the importance of attractiveness and of reaching the thin ideal (Moradi, Dirks, & Matteson, 2005). However, not
all women who are exposed to the Western culture develop eating disorders. Other factors that have been found to increase the risk of being affected by Western culture values are: social pressure to be thin (e.g. being exposed to media images, peer teasing, comments about losing weight), high socio-economic status, certain personality traits (e.g. perfectionism), high social anxiety, being overweight or obese, high impulsivity, genetic differences in the body’s reaction to starvation, and genetic differences in the rewards associated with starvation or with eating (Striegel-Moore & Bulik, 2007).

The following evidence has been proposed to support the sociocultural model of eating disorder etiology: (a) the prevalence of eating disorders among females (American Psychiatric Association [APA], 2002); (b) the increase in eating disorders which coincides with the decrease in the ideal body-size for women (Wiseman, Gray, Mosimann, & Ahrens, 1992; Hoek & van Hoeken, 2003); (c) more cases of eating disorders arise in cultures that value extreme female thinness; (d) significant prospective relationship between disordered eating and internalization of the thin-ideal (Striegel-Moore & Bulik, 2007). Longitudinal studies have consistently shown that body dissatisfaction among other important factors (i.e. thin-ideal internalization, elevated body weight, and dieting) predicts risk for onset or worsening of eating disorders (McKnight Investigators, 2003; Stice, 2002). For example, in a study of 1,177 adolescent girls, the authors found that body dissatisfaction and dieting predicted increased bulimic symptoms at 12-month follow-up (Johnson & Wardle, 2005). In another study, which followed over 11,000 boys and girls, the investigators found that a combined measure of thin-ideal internalization, teasing about weight, and dieting predicted the onset of binge eating and purging behaviors in girls (Field, Camargo, Taylor, Berkey, & Colditz, 1999; Field et al., 2002).
The sociocultural model describes the following steps of eating disorder etiology: exposure to the thin ideal (Western emphasis of extreme thinness as a beauty ideal), internalization of the ideal, experience of discrepancy between the self and the ideal, which leads to body dissatisfaction and dietary restraint. In some individuals, dietary restraint leads to overeating which increases body dissatisfaction and causes further restraint or purging (Striegel-Moore, Silberstein, & Rodin, 1986). The dual-pathway model of bulimic pathology hypothesizes that internalization of the thin ideal leads to body dissatisfaction, which increases dieting and negative affect (Stice & Agras, 1998).

Stice (2001) evaluated the dual-pathway model using a sample of 231 female students (M age = 14.9) from two private schools in California. Twenty percent of the sample identified as Asian, 4% Black, 65% Caucasian, 2% Hispanic, 1% Native American, and 8% as “other.” The participants completed a survey that evaluated perceived pressure to be thin, thin-ideal internalization, body dissatisfaction, dieting behaviors, negative affect, body mass and bulimic symptoms. Results showed that, as predicted by the dual-pathway model, pressure to be thin and thin-ideal internalization were significantly related to growth of body dissatisfaction over the 2-year study period. Also as predicted by the model, initial body dissatisfaction was significantly positively related to dieting and negative affect. Finally, both dieting and negative affect were significantly related to bulimic symptoms. The author concluded that thin-ideal internalization, pressure to be thin, body dissatisfaction, dieting and negative affect are risk factors the development of bulimic symptoms. However, dieting and negative affect appear to mediate the relationship between body dissatisfaction and onset of bulimic symptoms (Stice, 2001).

In a study of 398 female undergraduate students from a southwestern university (Brannan & Petrie, 2008), the investigators found a significant association between body dissatisfaction
and disordered eating. Body dissatisfaction accounted for 16% to 26% of the variance in measures of disordered eating. This relationship was moderated by neuroticism and body surveillance, such that higher levels of body dissatisfaction, combined with higher levels of the moderator were associated with higher levels of disordered eating. In another study of 114 female college students, the authors found significant positive correlations between viewing fashion or beauty magazines, appearance dissatisfaction, and disordered eating behaviors. Additionally, risk of disordered eating was associated with low self-esteem, body dissatisfaction and overall appearance dissatisfaction (Kim & Lennon, 2007). Furthermore, in a study of 334 undergraduate female students from a large southwestern university (Cohen & Petrie, 2005), the authors found that women with disordered eating endorsed similar levels of body dissatisfaction as women with diagnosable eating disorders. Furthermore, participants with disordered eating behaviors endorsed more body dissatisfaction than asymptomatic participants. The authors concluded that a large percentage of undergraduate female students are experiencing subclinical levels of disordered eating tendencies, and that these tendencies are linked to high levels of body dissatisfaction (Cohen & Petrie, 2005).

Ricciardelli, Tate, and Williams (1997) investigated the relationship between body dissatisfaction, dietary restraint and bulimic symptoms. The participants of the study were 172 first-year female psychology students recruited a university in Australia. The mean age of participants was 20.98 years ($SD = 5.25$). The participants filled out three measures which evaluated body dissatisfaction, dietary restraint and bulimic eating behaviors. Results showed that body dissatisfaction accounted for 36% of the variance in the amount of bulimic eating behaviors. Additionally, it was found that dietary restraint did not explain any unique variance in the amount of bulimic eating behaviors. The researchers concluded that body dissatisfaction
is a significant predictor of bulimic eating behaviors. In another study, Wertheim, Koerner, and Paxton (2001) examined the factors that predict restrictive eating and bulimic behaviors in adolescent girls. The participants were 435 girls from six high schools in Australia, mean age = 14.09. Results showed that body dissatisfaction and weight related teasing (to a smaller degree) both predicted increases in restrictive eating and bulimic behaviors (e.g. binge eating) over time. The authors concluded that body dissatisfaction and weight related teasing are risk factors for developing restrictive eating and bulimic behaviors.

In a study by Probst and Vancampfort (2008), the authors investigated mirror avoidance and mirror checking behaviors in females with eating disorders and nonclinical females. The authors argue that mirror checking behaviors are associated with body image, in that increased mirror checking is indicative of higher body dissatisfaction. The participants were 874 women with eating disorders and 1151 nonclinical control subjects. The participants filled out several surveys which explored their body image, mirror behaviors and drive for thinness. Results showed that participants with eating disorders observed themselves in the mirror more than nonclinical participants, indicating a higher level of body dissatisfaction in the females with eating disorders.

However, there are some studies that do not show a relationship between body dissatisfaction and disordered eating. For example, Keel, Fulkerson, and Leon (1996) investigated factors which predict disordered eating in girls. Study participants were 80 fifth-grade girls. Ninety two percent of the participants were Caucasian, 5% were of mixed race, 2% were African American, and less than 1% were Native American or Asian. The subjects filled out four inventories which assessed mood, body image, self-esteem, and pubertal development. Results showed that Body Mass Index and pubertal development predicted disordered eating.
The authors concluded that body image dissatisfaction was not a significant predictor of disordered eating in girls. It is important to point out, however, that this study had a small sample size, compared to an average of 1203 participants for studies showing significant relations between body dissatisfaction and eating pathology (Stice & Shaw, 2002).

Ball and Kenardy (2002) investigated the relationship between acculturation status and risk factors for eating disorders using a sample of 14,779 women in Australia. The participants filled-out a survey which included questions about length of time spent in Australia, body dissatisfaction, and disordered eating behaviors. Results showed that the longer time a participant spent in Australia, the more similar her weight-related beliefs and behaviors were to Australian-born women. The authors concluded that exposure to the eating practices and beliefs about weight of the dominant culture may seriously impact ethnic minorities, such that they may be more likely to internalize these values and practices in order to assimilate into Western society.

Relationships between body image, disordered eating and acculturation stress were examined in a study by Gordon, Castro, Sitnikov, and Holm-Denoma in 2010. The sample consisted of 276 females (27% Latina, 29% White, 44% Black) enrolled in introductory psychology courses at a large southeastern state university. Results showed that among Black women, the discrepancy between perceived body shape and perceived ideal body shape for the US predicted body dissatisfaction and drive for thinness; however, the discrepancy between perceived body shape and perceived ideal for their ethnic group only predicted body dissatisfaction, but not drive for thinness. Among Latina women, the discrepancy between perceived body shape and perceived ideal for their ethnic group predicted both body dissatisfaction and drive for thinness; however, discrepancy between perceived body shape and
perceived ideal for the US did not predict eating disorder symptoms. Additionally, results showed that higher levels of acculturative stress (defined as psychological and psychosocial stress experienced by an individual trying to fit into a new culture, which may be accompanied by adaptation of unhealthy coping strategies, such as extreme weight regulation), were related to increased body dissatisfaction among Black women, and increased drive for thinness among Latina women. The authors concluded that it is important to consider acculturation status and acculturative stress when working with ethnic minority women.

However, some studies have not found a relationship between acculturation and disordered eating. For example, Barry and Garner (2000), conducted a study to evaluate the relationship between acculturation and eating concerns of female East Asian immigrants in the US (N = 75). Results showed that eating concerns were related to psychological distress, but not to acculturation or ethnic identity (Barry & Garner, 2000). However, in a study of 353 women from various ethnic backgrounds, the authors found that a higher acculturation to US culture resulted in more unhealthy eating attitudes among Eastern-European immigrants. Furthermore, Eastern-European descended women continued to have a more negative body image and were at a higher risk for eating disorders, as compared to African-descended women who had a more positive body image and were at a lower risk for eating disorders (Sussman, Truong & Lim, 2006).

There has not been an abundance of studies involving Eastern-European women and body dissatisfaction or eating disorders. However, there have been several investigations that point to the fact that Eastern-European women are at a similar risk of developing body dissatisfaction and eating disorders as women from a Western culture. For example, O’Keefe and Lovell (1999) compared Eating Disorder Inventory-2 (EDI-2, Garner, 1991) scores in Russia
and in Great Britain. The EDI-2 is a measure of eating pathology with 11 scales that assess drive for thinness, perfectionism, impulsivity, and fears of maturity among others. Participants were female undergraduate students between the ages of 17 and 25. There were 251 Russian students, mean age = 19.49 (SD = 1.93), and there were 66 British students, mean age = 20.06 (SD = 2.31). The women were recruited through requests to participate in a health-related investigation. The respondents met with the authors individually / completed the EDI-2. The height and weight of respondents was also measured and they were asked whether they were currently on a diet to lose weight. Results showed that Russian women had a significantly lower BMI than did British women. Additionally, Russian women had a significantly lower desired BMI than did women from Britain. A higher percentage of Russian respondents were underweight than overweight (13.7 % vs. 4.4 %). On the other hand, a higher percentage of British women were overweight than underweight (6% vs. 14%). Furthermore, there were significantly more British respondents that were on a diet than Russian respondents that were on a diet. Finally, Russian respondents scored significantly higher on 5 of the 11 subscales of the EDI-2: drive for thinness, perfectionism, maturity fears, asceticism and impulsivity. The authors concluded that Russian women are at risk for developing eating disorders.

In a similar study, Bilukha and Utermohlen (2002) conducted a study in which they assessed body image, internalization of the Western thin-ideal and dieting practices in 616 Ukrainian females. The convenience sample of participants aged 18-60 was drawn around the city of Lviv in Ukraine. The participants completed a questionnaire about their food intake, Western media exposure, awareness of and internalization of the thin-ideal, and body dissatisfaction. Results showed that 53.7% of women desired a thinner figure, but only 16.4% of women were actually overweight. Approximately 25% of underweight women and 60% of
normal weight women wanted to be thinner. Western media exposure was significantly correlated with internalization of the thin-ideal, and higher levels of internalization were significantly associated with a thinner Ideal figure and more body dissatisfaction. Western media exposure was not correlated with body dissatisfaction after adjusting for BMI. Additionally, dieters had significantly higher levels of internalization and body dissatisfaction. The authors concluded that the ideal figure of the Ukrainian sample as slender as the ideal figure of the American sample. Additionally, this study lends further support to the sociocultural model: Western media exposure led to internalization of the thin-ideal in the Ukrainian women, which, in turn led to body dissatisfaction and dieting. These results are similar to findings in the American population (Heinberg et al., 1995).

Forbes, Doroszewicz, Card, and Adams-Curtis (2004) investigated the relationship between sexism, body dissatisfaction and internalization of the thin-ideal of Polish women and women in the United States. Participants from Poland were 111 women from beginning psychology courses at a local university ($M$ age = 19.63, $SD$ = 1.0). Participants from the US were 83 women from psychology courses at a small university in Illinois ($M$ age = 20.34, $SD$ = 0.98). It is important to note that the Polish sample had a significantly smaller BMI than the American sample. The participants completed several measures including: benevolent and hostile sexism scales, self-esteem scale, a measure of body satisfaction, assessment of internalization of the thin-ideal, a scale of cosmetics use, and a current/preferred body size silhouette measure. Benevolent sexism is defined as chivalrous, idealistic, traditional ideas about women in societies where men hold most of the power and women and men are not competing for the same social positions and resources. Women are generally more accepting of benevolent
sexism because it offers protection and rewards for women in traditional gender roles. Hostile sexism is defined as negative beliefs held about nontraditional women (Glick et al. 2000).

Results showed that, with BMI controlled, the Polish sample had the same amount of body dissatisfaction as the US sample. Additionally, the Polish women chose a significantly larger perceived body, even though their BMI’s were actually smaller. Results also showed that Polish women held more sexist beliefs than American women. Additionally, the Polish sample had smaller thin-ideal internalization scores than the American sample. Finally, it was found that benevolent sexism was inversely related to preferred body size (i.e. more sexism = smaller desired body). In the Polish sample, increases in benevolent sexism were also associated with more favorable attitudes towards cosmetics use. For both samples increased self-esteem was associated with less body dissatisfaction, and increased awareness and internalization of the thin-ideal was associated with decreased self-esteem and more body dissatisfaction. In the Polish sample, increased internalization was associated with increased perceived body size and a bigger discrepancy between the current and the desired body size (Forbes et al., 2004).

Authors concluded that the women in the Polish sample were not greatly different from the women in the US sample. With BMI statistically controlled, the two samples did not differ significantly on body dissatisfaction, self-esteem, internalization of the thin ideal or use of cosmetics. The Polish responders scored significantly higher on measures of sexism and there were several significant relationships between sexism and body measures or cosmetics use. These results appear to indicate that sexism affects Polish women more than it affects US women. These findings also show that internalization of the thin-ideal and media depictions of beauty are more influential in the US than in Poland. The authors state that the similarities
between the two samples support the idea that the Western thin-ideal is spreading and becoming
globalized (Forbes et al., 2004).

It is also important to mention that higher levels of both benevolent and hostile sexism
were found in Poland. Franzoi (2001) argues that in traditional societies where men hold most of
the social and economic power and women and men do not compete for the same social positions
and resources, it is common for women to exchange attractiveness and sexual availability for
protection and admiration from men. Thus, in such societies there should be an increased use of
cosmetics and an emphasis on sexual attractiveness. In a study of US college women, cosmetics
use was positively correlated with the benevolent sexism scale and negatively correlated with the
hostile sexism scale. In the Polish sample there was a significant correlation between the number
of cosmetics typically used on dates and the score on the benevolent sexism scale. No such
correlation was detected in the US sample, indicating that there is more benevolent sexism in the
Polish sample (Forbes et al., 2004).

Furthermore, the authors speculate that women who endorse higher levels of benevolent
sexism and who are, therefore, interested in attracting men to admire and protect them could be
more concerned about their weight and shape. This concern could lead to a stronger connection
to the thin-ideal than in women who endorse low levels of benevolent sexism. Studies also
indicate (Lee & Lee 2000; Nasser, Katzman, & Gordon, 2001) that body dissatisfaction, desire
for thinness and disordered eating are prevalent in societies in transition – those with changing
values and gender roles, as well as with role conflicts and gender competition. The results of this
study indicate that there is more transition and gender competition in the US than in Poland.
Furthermore, US society has been transitioning to a more egalitarian social system in recent
years (Swim, Aikin, Hall & Hunter, 1995). Therefore, it is important to investigate immigrants
from Eastern Europe to the United States, as they will be exposed to a society in transition and to gender role changes that they may not know how to deal with appropriately. It is possible that Eastern European immigrants to the United States are at a greater risk for disordered eating than native-born Americans, because Eastern European immigrants are likely to be experiencing an even greater amount of cultural transition than native-born Americans typically experience.

Yakushko (2005) found similar results in her study of benevolent and hostile sexism of men (n=38) and women (n=138) in Ukraine. Results showed that Ukrainian women have stronger benevolent sexist beliefs about their gender roles than the male participants. This further supports the theory that in cultures were women are expected to fulfill more traditional gender roles, women often hold strong benevolent sexist attitudes about themselves (Glick & Fiske, 2001). Levant et al. also (2003) found that women and men in Russia hold more traditional gender role values than Americans. In a similar study, Pecova and von Wietersheim (2005) compared 328 Czech and German women on their eating behaviors and traits they associated with female role models. Results showed that women from the Czech Republic had lower ideal BMI and had more body dissatisfaction than women from Germany. Additionally, Czech participants chose more independent and nontraditional traits for their female role models (e.g. following own goals, competent in job). The authors concluded that Czech women may be at a higher risk for eating disorders than German women. Furthermore, this contributes evidence toward the theory that in cultures undergoing gender-role transition women are at a higher risk of developing eating disorders.

The relationship between romantic partner ethnicity and body dissatisfaction has not been studied, however, multiple studies have shown a link between romantic relationships and body dissatisfaction. For example, Markey and Markey (2006) investigated the association between
body image and romantic relationships of 95 women ($M$ age = 22.46). Participants were recruited from a campus of a northeastern university and the surrounding area. Women rated their satisfaction with their bodies, perceptions of their partners’ satisfaction with their bodies, and their satisfaction with the relationship. The authors also obtained the partners’ actual satisfaction with the women’s bodies. Results showed that women were more dissatisfied with their bodies than they perceived their partners’ to be, and women were more dissatisfied with their bodies than their partners actually were. Furthermore, results indicated that women who were in long term relationships were more likely to falsely believe that their partner wanted them to have a smaller body size. In a similar study, Boyes, Fletcher, and Latner (2007) were investigating unhealthy dieting and body dissatisfaction in the context of romantic relationships. The authors surveyed 57 predominantly unmarried couples, recruited from a university in New Zealand. Results showed that women with high-self esteem and less depressive symptoms had higher body satisfaction and less dieting behaviors. On the other hand, women whose male partners had more depressive symptoms and were less satisfied with the relationship, experienced more body dissatisfaction and dieted more. The authors concluded that relationship processes are associated with body satisfaction and dieting behaviors.

Additionally, a study by Ambwani and Strauss (2007) also showed a connection between body experiences and romantic relationships. The authors recruited 113 females ($M$ age = 20.13, $SD = 1.47$) from a small midwestern liberal arts college. Participants filled out surveys regarding body image and relationship experiences. Authors found significant correlations between relationship experiences and body image. Furthermore, two relationship factors (trust and jealousy) predicted body dissatisfaction in participants. Women also reported that relationships affect their self-confidence.
However, not all studies show a link between romantic relationships and body dissatisfaction. Sheets and Ajmere (2004) surveyed 362 undergraduate female ($M$ age = 19.1) students from Introductory Psychology courses, recruited a medium-sized mid-western state university. The researchers found that weight is negatively correlated with relationship satisfaction in women. Additionally, results showed that over 30% of women in exclusive relationships have been told by their partner to gain or lose weight, which decreased their relationship satisfaction. The study did not find a difference in dieting efforts between women who have been told to lose weight, and women who have not been told to lose weight. The authors concluded that there is no relationship between women’s weight loss attempts and being the target of weight-loss comments by their partners. However, for the women who have been told to lose weight and who were dieting, it is unclear whether their weight-loss efforts were motivated by the weight-loss comments (Sheets & Ajmere, 2004).

Finally, in a study by Morrison, Doss, and Perez (2009), the authors investigated the association between eating, weight, shape (EWS) concerns and romantic relationships of 88 women ($M$ age = 18.65, $SD = 0.88$) recruited from a large southern university. Results showed that men’s desired change in their partners’ bodies predicted changes in EWS concerns in women. Furthermore, men’s desired change in their partners’ bodies affected women’s relationship outcomes. The authors concluded that the association between relationship functioning and EWS concerns is bidirectional, as particular changes in women’s EWS concerns predicted men’s relationship outcomes two months later (Morrison, Doss & Perez, 2009).

**Method**

**Participants**
Participants are 69 women between ages of 18 to 65 ($M = 37.35, SD = 12.04$), who were born in or are first generation immigrants from Eastern-Europe (Russia, Belarus, Lithuania, Latvia, Poland, Ukraine, Estonia, Albania, Bulgaria, Croatia, Czech Republic, Hungary, Macedonia, Moldova, Romania, Bosnia & Herzegovina, Serbia, Montenegro, Slovakia, Slovenia, Kazakhstan, Uzbekistan), and who are involved in a heterosexual relationship. Tables 1, 2 and 3 show a summary of participant and participant partner demographic information.

Table 1
*Participant Ethnicity, Race and Immigration Status*

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<th>Country of Origin</th>
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<th>Percent</th>
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<th>Immigration Status</th>
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Table 2
*Participant Partners’ Ethnicity and Race*

<table>
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<tr>
<th>Ethnicity</th>
<th>Percent</th>
<th>n</th>
<th>Race</th>
<th>Percent</th>
<th>n</th>
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<tr>
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<td>White</td>
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<td>----</td>
<td>-----</td>
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<td>Black</td>
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<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
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<td>Other</td>
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Table 3

**Participant Demographic Information**

<table>
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<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Age (years)</td>
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<td>12.04</td>
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<tr>
<td>Weight (pounds)</td>
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<td>28.01</td>
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<tr>
<td>Height (feet’inches)</td>
<td>5’44</td>
<td>3.44</td>
</tr>
<tr>
<td>BMI</td>
<td>24.42</td>
<td>5.10</td>
</tr>
</tbody>
</table>

**Procedure**

After receiving Institutional Review Board approval, the participants were recruited by using social networking websites (www.facebook.com, www.craigslist.com, www.odnoklassniki.ru, www.russianseattle.com), by placing flyers in culturally relevant locations (Eastern-European restaurants, stores, churches), and by contacting people who may have access to that population (e.g. heads of Eastern-European exchange programs at Universities, Russian language teachers, etc.). Finally, investigator’s personal contacts were recruited as participants and asked to pass the information about the study along to other potential participants.

After obtaining informed consent, participants of the study were asked to fill out a web-based survey (www.surveymonkey.com). As an incentive to complete the survey, participants were offered an opportunity to enter a drawing for one of four 20$ gift certificates at the end of
the survey. Participants who chose to enter the drawing provided their email addresses in a separate survey, such that their contact information could not be associated with survey responses.

**Measures**

**Demographic Characteristics**

The demographic questionnaire included self-reported responses about age, height in feet and inches (\( M = 5'5''\), \( SD = 3.4''\)), weight in pounds (\( M = 141.7\), \( SD = 28.0\)), race, ethnic heritage or country of origin, immigration status, length of time in the U.S. in years (\( M = 12.4\), \( SD = 8.3\)), native language and other languages spoken, ethnicity of partner (American, Eastern-European, or other), and race of partner.

**Body Shape Questionnaire – Short (BSQ-S)**

Body dissatisfaction was measured using the short version of the Body Shape Questionnaire. BSQ-S consists of 14 items and is used to assess the frequency of experiencing concerns and negative feelings about body shape. Frequency is rated on a 6-point Likert-type scale including the following answer options: 1) Never, 2) Rarely, 3) Sometimes, 4) Often, 5) Very Often, 6) Always. Total scores range from 14 (low body dissatisfaction) to 84 (high body dissatisfaction). BSQ-S has been psychometrically validated and has strong internal reliability (0.93) as well as good construct validity (Dowson & Henderson, 2001).

**Eating Attitudes Test – 26 (EAT-26)**

The EAT-26 is used to identify maladaptive eating patterns and concerns about weight. There are 26 statements about food, weight and eating behaviors with which participants rate their agreement on a 6-point scale: 1) Always, 2) Usually, 3) Often, 4) Sometimes, 5) Rarely, 6) Never. A score of 20 or above indicates the presence of abnormal eating behaviors. Three
factors have been identified within this measure – dieting, food preoccupation, and oral control. The measure generates a total score as well as subscores for the three factors. The EAT-26 has been psychometrically validated and has both high reliability and strong validity (Garner, Olmsted, Bohr, & Garfinkel, 1982).

Relationship Assessment Scale (RAS)

The RAS is a 7-item questionnaire which assesses the satisfaction with a romantic relationship. The items are questions about the quality of the relationship and satisfaction with the partner. There are five answer options: A) Low satisfaction, B), C) Average, D), E) Extreme satisfaction. The answers are assigned scores between 1 (low satisfaction) and 5 (high satisfaction), and the total score is the calculated mean of the seven item scores. Scores over 4 typically indicate non-distressed couples, and scores between 3.0 and 3.5 are associated with increased distress and substantial relationship dissatisfaction. The measure has high internal consistency reliability (0.86) and strong concurrent validity (0.80) with other measures of romantic satisfaction (Hendrick, 1988).

Vancouver Index of Acculturation (VIA)

The VIA is a 20-item self-report questionnaire which assesses an individual’s connection to his/her heritage culture. The VIA has two scales: the Mainstream scale which measures the individual’s orientation to the dominant culture (in this study - white American culture; VIAA) and the Heritage scale which measures orientation to the heritage culture (VIAH). The VIA consists of ten statements which relate to the Mainstream culture and ten statements which relate to the Heritage culture. The ten statements are the same for Mainstream culture and Heritage culture. Answer options are on a 9-point rating scale, with 1 being “Strongly Disagree” and 9 being “Strongly Agree.” The Heritage subscore is the mean score obtained on the ten items
about the heritage culture, and the Mainstream subscore is the mean score obtained on the ten
items about the dominant culture. The items assess three areas of acculturation: values, social
relationships and adherence to traditions. Higher scores indicate higher association with the
respective culture. The VIA was validated with various cultures and found to have high internal
consistency reliability (> 0.90). The VIA is also significantly correlated with other acculturation
measures and thus has high concurrent validity (Ryder et al., 2000). For this study, we wanted to
isolate the body image message from the dominant American culture, which is why the
Mainstream scale specifically targets “white” American culture.

Results

The purpose of this study was to determine whether partner ethnicity affects eating
behaviors and body dissatisfaction in a sample of female Eastern-European immigrants in the
United States. Means, standard deviations and Pearson moment correlations between the
variables are presented in Tables 4 and 5.

Table 4
Correlations Among the BSQ, EAT-26, BMI, RAS, VIAA, VIAH, & Partner Ethnicity

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
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<td>1. BSQ</td>
<td>--</td>
<td>.57**</td>
<td>.36**</td>
<td>-.33**</td>
<td>.02</td>
<td>-.11</td>
<td>-.06</td>
</tr>
<tr>
<td>2. EAT-26</td>
<td></td>
<td>--</td>
<td>.18</td>
<td>-.30*</td>
<td>.05</td>
<td>-.26*</td>
<td>.21</td>
</tr>
<tr>
<td>3. BMI</td>
<td></td>
<td></td>
<td>--</td>
<td>-.31*</td>
<td>.16</td>
<td>-.02</td>
<td>-.11</td>
</tr>
<tr>
<td>4. RAS</td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>-.29*</td>
<td>.11</td>
<td>.02</td>
</tr>
<tr>
<td>5. VIAA</td>
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<td></td>
<td></td>
<td></td>
<td>--</td>
<td>.09</td>
<td>.10</td>
</tr>
<tr>
<td>6. VIAH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>-.40**</td>
</tr>
<tr>
<td>7. Partner Ethnicity</td>
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<td></td>
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</tr>
</tbody>
</table>

**p < .01
*p < .05
A significant positive relationship was found between BSQ and EAT-26, indicating that women reporting higher body dissatisfaction endorse more disordered eating behaviors. There was a significant negative relationship found between BSQ and RAS, as well as between EAT-26 and RAS. This suggests that as body dissatisfaction and disordered eating increases relationship satisfaction tends to decrease. There was also a significant negative relationship found between RAS and VIAA, indicating that as acculturation to the white American culture increases, relationship satisfaction decreases. There was a significant negative relationship found between EAT-26 and VIAH, indicating that as acculturation to the heritage culture decreases – disordered eating tends to increase. In addition, there was a significant negative relationship found between BMI and RAS, which suggests that as BMI increases relationship satisfaction decreases. Finally, there was a significant relationship between VIAH and partner ethnicity, indicating that women who greatly identify with their Eastern-European heritage culture also tend to be in relationships with Eastern-European partners.

To address the question of whether partner ethnicity (Eastern-European vs. non Eastern-European) affects body dissatisfaction and disordered eating in female Eastern-European immigrants a MANCOVA analysis was conducted. Results showed that controlling for relationship satisfaction, acculturation and BMI there was no significant differences in body dissatisfaction and disordered eating between women whose partners were Eastern-European (BSQ $M = 37.96$, $SD = 12.51$; EAT $M = 6.68$, $SD = 5.06$) and women whose partners were not Eastern-European (BSQ $M = 37.04$, $SD = 13.80$; EAT $M = 10.52$, $SD = 10.10$).

Table 5

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>BSQ</th>
<th></th>
<th>EAT-26</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Eastern-European</td>
<td>37.96</td>
<td>12.51</td>
<td>6.68</td>
<td>5.06</td>
</tr>
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</table>
This suggests that factors other than partner ethnicity affect body dissatisfaction and disordered eating in female Eastern-European immigrants in the United States.

**Discussion**

The purpose of this study was to evaluate whether partner ethnicity affects body dissatisfaction and disordered eating behaviors of female Eastern-European immigrants in the United States. The results of this study showed that partner ethnicity does not affect body dissatisfaction and disordered eating behaviors of female Eastern-European immigrants in the United States. These findings indicate that, for Eastern-European immigrant women, factors other than partner ethnicity including acculturation, relationship satisfaction and BMI influence body dissatisfaction and disordered eating behaviors. The results of this study showed that as acculturation to the heritage culture decreases – disordered eating behaviors increase. This finding is supported by several studies which showed that immigration and acculturation stress is a risk factor for developing disordered eating (Bulik, 1987; Ball & Kenardy, 2002; Gordon, et al. 2010). This study indicates that identification with a non-Western heritage culture may serve as a protective factor against developing disordered eating. Perhaps, strong identification with a non-Western heritage culture prevents women from identifying with and internalizing the thin-ideal typically promoted in Western-oriented societies (Striegel & Bulik, 2007).

Furthermore, significant negative relationships were found between relationship satisfaction and body dissatisfaction, and relationship satisfaction and disordered eating. This suggests that Eastern-European women who are dissatisfied with their relationships are also more likely to have a higher BMI and to endorse higher levels of body dissatisfaction and disordered eating behaviors. Studies have shown that women with higher levels of body
dissatisfaction and disordered eating experience decreased self-esteem and increased negative affect (Stice, 2001; Boyes, Fletcher, & Latner, 2007) which may affect their romantic relationships. Or perhaps body dissatisfaction and disordered eating behaviors in and of themselves are factors that can cause strain in romantic relationships of Eastern-European female immigrants. Furthermore, women who reported high identification with the White American culture also reported increased relationship dissatisfaction. This is an interesting finding, in light of the fact that there were no significant correlations between VIAA and partner ethnicity, indicating that these women did not have a preference of Eastern-European vs. American partners. Perhaps Eastern-European women who are highly acculturated to the White American culture experience more identity conflicts, which may lead to increased conflicts within the relationship. Or perhaps women who are high on VIAA experience more dissatisfaction when they are with Eastern-European men, which could partially explain this finding.

Results of this study also showed that women who highly identify with their Eastern-European heritage tend to be in relationships with Eastern-European men. Perhaps women high on VIAH are drawn to men with similar cultural values and lifestyle, therefore tending to choose men of an Eastern-European background. In summary, this study showed that body dissatisfaction and disordered eating behaviors of Eastern-European female immigrants in the United States may be affected by the interplay of factors, such as relationship satisfaction and acculturation. Furthermore, the results of this study indicate that acculturation, BMI, body image and disordered eating may play a role in relationship satisfaction of Eastern-European female immigrants in the United States.

This study had several strengths. One of them is the fact that this study involved a rarely investigated population; a population that, nevertheless, makes up a large portion of the United
States. Another strength of this study is that despite the specificity of the population and the narrow criteria for participation in this study – a good sample size was obtained. A sample-size analysis was conducted using G-Power (Erdfelder, Faul, & Buchner, 1996) and a sample of 32 participants was recommended. The sample size of this study exceeded this recommendation, thus increasing the power of the study (Kazdin, 2003). Furthermore, well-validated instruments were used in this study, which increased the validity of this study (Dowson & Henderson, 2001; Garner et al., 1982; Hendrick, 1988; Ryder et al., 2000; Kazdin, 2003).

However, as any investigation, this study has several weaknesses. One of them is that due to the specificity of the population investigated in the study convenience sampling was used (Kazdin, 2003). Another weakness of this study is the use of an internet survey to collect data. Internet survey use may have allowed people who did not actually meet the participation criteria to complete the survey. It also increased the possibility of people selecting random answers in order to participate in the gift-certificate drawing. Finally, a self-report format was used to collect height and weight data. Research indicates that this method is often unreliable due to inaccurate reporting of height and weight, which can lead to significant errors in calculating the BMI (Meyer, McPartlan, Sines, & Waller, 2009).

In future studies it may be interesting to investigate whether partner acculturation plays a role in body dissatisfaction and disordered eating behaviors or Eastern-European female immigrants in the United States. Additionally, future studies may involve a more in-depth investigation of the relationship between identification with the heritage culture and disordered eating. It will be interesting to determine whether association with the heritage culture truly serves as a protective factor against disordered eating in female Eastern-European immigrants in the United States. Perhaps including a measure of internalization of the thin-ideal will be helpful.
in answering this question. In addition, it will be important to conduct a comparative study in which body dissatisfaction and disordered eating behaviors of Eastern-European female immigrants in the United States is compared to body dissatisfaction and disordered eating behaviors of women living in Eastern-Europe. Finally, future studies may further elucidate how female BMI, body dissatisfaction and disordered eating behaviors affect romantic relationship satisfaction. A study in which both partners’ relationship satisfaction is measured may help to clarify this relationship.
References


Pecova, V. & von Wietersheim, J. (2005). Eating behavior differences and the perception of
gender roles in Czech and German nonclinical samples. *Eating and Weight Disorders, 10*, 83-90.


