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The Impact of Discrimination and Microaggressions on Binge Eating Behaviors Among Black Women: A new framework of the development and maintenance of binge eating

Salomé Wilfred

wilfred@uthscsa.edu

The University of Texas Health Science Center at San Antonio

Carolyn Becker

Trinity University

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Abstract

Background

Dietary restraint, emotion dysregulation, and perceived stress are significant predictors of binge eating (BE) behavior. Limited research, however, has evaluated unique lived experiences that might contribute to BE in Black women living in the United States, which is problematic because Black women report the highest rates of BE behaviors across all racial and ethnic groups. One factor unique to Black women includes experiences with discrimination and microaggressions, both of which are a distinct form of stress. Therefore, the current study examined the relationship of experiences with discrimination and microaggressions and BE behaviors.

Methods

A total of 197 Black women were recruited through snowball sampling and completed the self-report questionnaires. Participants completed self-report measures assessing eating behavior, emotion dysregulation, perceived stress, and experiences with discrimination and microaggressions.

Results

Separate multiple regression analyses indicated that experiences with discrimination and microaggressions predicted BE behaviors above and beyond dietary restraint, emotion dysregulation, and perceived stress.

Conclusion

Experiences with discrimination and microaggressions predicted BE behavior above and beyond well-established causal and maintaining factors. Future research and clinical work should better assess and integrate the experiences of Black women to improve both the understanding of and treatment for BE among Black women.

Plain English summary

Dietary restraint, emotion dysregulation, and stress are significant causal and maintaining factors for binge eating behavior. These findings are not generalizable since most studies lacked diversity, and most participants were White women. Prevention and intervention programs that are based on the current theory are less effective when they are conducted with Black women. This is likely because of different lived experiences which may be playing a role in binge eating behaviors for Black women. Experiences with discrimination and microaggressions are two potential factors; both of which have a negative impact on marginalized people's well-being. This project investigated experiences with discrimination and microaggressions as unique contributing and predictive factors. Results of this investigation demonstrated that experiences with discrimination and microaggressions predicted binge eating in a sample of Black women.

Background

Binge eating disorder (BED) affects 2.4% of the population [1], making it the most prevalent and diagnosed eating disorder. Binge eating (BE) behavior, however, is even more prevalent and a diagnostic feature of other eating disorders [1]. Due to its prevalence, decades of research have focused on the etiology and maintenance of BE behavior, including the roles of dietary restraint, emotion dysregulation, and stress.

Models of BE development and maintenance propose that dietary restraint [2.3], emotion dysregulation [4] and stress [5–7] are significant predictors of BE. Importantly, research supports the contention that engaging in dietary restraint makes one more suspectable to engage in BE behavior [2, 8, 9]. Theory also suggests BE can function to reduce negative affect when feeling elevated emotional distress [4] and heightened levels of general stress [10]. For example, using experience sampling, Sultson and colleagues [11] found support for the theory that emotion dysregulation predicts BE behaviors. Their investigation found that participants reported higher negative affect prior to BE episodes. Similarly, using ecological momentary assessment (EMA) Smith et al., [12] found that cumulative buildup of stress over recent hours (not short-term fluctuations of stress) was a significant predictor of BE episodes with individuals diagnosed with BED. It is worth noting that interventions for BE have been designed to address each of these identified causal and maintaining factors [13].

While Black women are 2–3 times more likely to engage in BE behaviors compared to women from other racial and ethnic groups [14–16] treatment approaches have often centered the experiences of White women. This has resulted in the decreased efficacy and effectiveness of BE treatment for Black women [17]. Notably, research has found significant disparities in treatment access and retention, finding that fewer than 8% of Black women seek treatment for their BED [18–19]. Moreover, the small percentage of Black women who do begin treatment are more likely to drop out compared to White women [20]. In a systematic review, Goode [21] identifies several factors that should be considered in the development and treatment of BE among Black women. One key factor is the lived experiences of Black women, who exist at the intersection of being Black and female [22]. This unique experience, within systems of racism and gendered racism, presents challenges and suggests the possible function of racism and discrimination as contributing factors in disordered eating behaviors. Indeed, research on the impact of discrimination indicates that racism is a significant stressor found to negatively impact the biological and psychological health of Black Americans [23].

The Minority Stress Model [24] suggests that interactions specific to marginalized individuals cause psychological distress. One example of this psychological distress is vigilance. Vigilance occurs in anticipation of rejection or discrimination associated with one's identity. Although this acts as a coping mechanism in the short-term, repeated vigilance leads to heightened levels of stress and emotional dysregulation. Similarly, Smith coined the term Racial Battle Fatigue [25–26] which is defined as an emotional response to daily encounters with discrimination and microaggressions. Like the Minority Stress Model, Racial Battle Fatigue has been linked to increases in negative emotions and a decrease in

psychosocial resources [27]. In support of these theories, Bravo et al [28] surveyed 2,230 college students and found that experiences of discrimination were related to higher stress appraisal, depression, anger, anxiety, suicidal ideation, and sleep disturbances.

Research has also demonstrated the negative impacts of discrimination and microaggressions on one's psychosocial resources [29]. One theory to explain this is the self-regulation model. Based on this model, self-regulation is a limited resource that depletes each situation one encounters that requires self-regulation [30–31]. Encounters involving discrimination or microaggressions require cognitive and emotional energy resulting in decreased self-regulation ability. Banks and Landau [29] demonstrated this in an investigation among Black college women who were exposed to microaggressions. Investigators found that Black women exposed to microaggressions demonstrated greater decreases on tests of cognitive functioning compared to women who were not exposed to microaggressions. While self-regulatory strength can be restored, sufficient rest is required [30]. But experiences with microaggression are prevalent and "are as much a part of our lives as the air we breathe" [31 p. 34] making the associated stress and negative affect different for Black women.

Few studies have examined the relationship between experiences with discrimination and microaggressions and BE behaviors. In one of the few exceptions, Kelly and colleagues [14] examined discrimination, emotion dysregulation and loss of control among African American, Asian American, and Hispanic/Latino men. Among African American participants they found that experiences with discrimination were associated with loss a control, a diagnostic requirement for BE. Although these findings are important, the sample only included men. Another investigation examined discrimination and BED among Black men and women. This study supported a positive association between discrimination and BED [32], consistent with Kelly and colleagues' [14] findings. While this study assessed the relationship between discrimination and BED among men and women, it did not assess other factors potentially leading to BE behaviors such as negative emotionality and daily stressors.

The aim of the current investigation was to assess if experiences with discrimination and microaggressions influence BE among Black women living in the United States (US). Given that discrimination and microaggressions are common experiences of Black women living in the U.S., and that previous research has demonstrated a relationship between experiences with discrimination and loss of control eating [14], as well as BED [32], this study aimed to further investigate the relationship between discrimination and microaggressions and BE, specifically among Black women living in the U.S. We hypothesized that experiences with discrimination and microaggressions would account for variance in BE behaviors above and beyond the known precipitating and maintaining factors of dietary restriction, emotion dysregulation, and stress.

Methods

Procedures

Participants were recruited through advertisements on social media (i.e, Instagram, X, listservs, etc.) and flyers posted in community centers and coffee shops. Participants were provided a link to the study surveys administered through Qualtrics. After receiving an online description of the survey through Qualtrics, participants provided informed consent and completed study questionnaires. To limit the potential inclusion of Bots in the data, various validity checks were used throughout (i.e., basic arithmetic and Honeypots). A total of 199 responses were deleted and excluded from analyses due to bot suspicion.

Participants

A total of 237 Black adult women living in the United States were recruited for the study. Fourty responses were deleted due to not completing all the assessments, leaving the total at 197 included in the analyses below. The mean participant age was 36 years (range 18–74 years). The sample was predominately African American (76.1%), with the remainder representing African (N = 39), American Descendants of Slavery (N = 24), Afro Latina (N = 6), Caribbean (N = 6); Caribbean American (N = 18); Other (N = 7). Among the participants, 82.6% identified as heterosexual. Most of the participants identified as single (52.7%) and held a bachelor's degree or higher (55.7%).

Measures

Eating Behaviors

Eating Disorder Examination Questionnaire- Restraint Subscale. The Eating Disorder Examination Questionnaire [EDE-Q; 33] is a 32-item self-report questionnaire that assesses feelings, attitudes, and behaviors regarding body image and disordered eating. The EDE-Q consists of four subscales: Restraint, Eating Concern, Shape Concern, and Weight Concern. The Restraint Subscale was used to assess the degree to which participants engaged in dietary restraint. Items are rated on a seven-point Likert Scale (*zero = no days to six = everyday*), with higher scores indicating greater symptomatology. The EDE-Q Restraint subscale demonstrated good internal consistency for the current sample, Cronbach's α = .80

Gormally Binge Eating Scale. The Gormally Binge Eating Scale [GBES; 34] is a 16-item self-report questionnaire that assesses the behavioral and cognitive factors related to BE. Items are rated on a range of severity (*zero = no binge eating problem to three= severe binge eating problem*), with higher scores indicating greater severity of BE behaviors. The GBES demonstrated good internal consistency for the current sample, Cronbach's α = .95

Stress and Emotion Regulation

Perceived Stress Scale. The Perceived Stress Scale [PSS; 35] is a 10-item self-report questionnaire that assesses the extent to which individuals consider situations in their daily lives as stressful. Items are

rated on a five-point Likert Scale (*zero = never to four = very often*), with greater scores indicating greater perceived stress. The PSS demonstrated good internal consistency for the current sample, Cronbach's α = .82

Difficulties with Emotion Regulation-Short Form. The Difficulties with Emotion Regulation Scale-Short Form [DERS-SF; 36] is an 18-item self-report measure that assesses emotion regulation deficits. The DERS-SF consists of six subscales: limited access to emotion regulation strategies, nonacceptance of emotional responses, impulse control difficulties, difficulty engaging in goal-directed behavior, lack of emotional awareness, and lack of emotional clarity. The DERS-SF total score was used to assess difficulties with emotion regulation. Items are rated on a five-point Likert scale (*one = almost never to five = almost always*), with higher scores indicating greater emotion regulation difficulty. The DERS-SF demonstrated good internal validity for the current sample, Cronbach's α = .89

Discrimination and Microaggressions

Everyday Discrimination Scale. The Everyday Discrimination Scale [EDS; 37] is a 10-item self-report measure that assesses experiences with unfair treatment that one perceives is due to their identity. Items on the EDS are rated on frequency (*zero = never to six = almost every day*), with higher scores indicating more experiences of discrimination. Responders indicated what they believed to be the main reason for their discrimination (i.e., gender, age, race, religion, sexual orientation, etc.). Responses indicating the main reason was race were included in the analyses. The EDS demonstrated good internal consistency for the current sample, Cronbach's α = .91

Racial Microaggression Scale. The Racial Microaggressions Scale [RMAS; 38] is a 32-item self-report measure that assesses experiences with race-based microaggressions. The RMAS consists of six subscales: Foreigner/not belonging, Low Achieving/Undesirable Culture, Criminality/Assumption of Criminal Status, Sexualization, Environmental Invalidations, and Invisibility. Experiences with these microaggression are rated on a four-point Likert scale (*zero = never to three = often/frequently*). If the participant endorses any of the items, they are then asked to indicate how stressful, upsetting, or bothersome the experience was for them on a four-point Likert scale (*zero = not at all to three = high level*). Two scores were calculated: a total score for experiences with all forms of microaggressions RMAS Experiences) and a total score for stress (RMAS Stress) associated with all forms of microaggressions; higher scores indicate more experiences and more stress, respectively. The total score for RMAS Experiences demonstrated good internal consistency for the current sample Cronbach's α = .97. The RMAS Stress score also demonstrated good internal validity, Cronbach's α = .97.

Data Analysis

Three hypotheses were tested to evaluate the variance in BE behavior. For our first hypothesis, we predicted that experiences with discrimination would account for variance explained in BE, beyond dietary restraint, emotion dysregulation, and stress. A multiple regression was conducted with BE behavior as the outcome variable. Scores on measures assessing dietary restraint, emotion

dysregulation, and perceived stress were entered in the first block. Scores on the measures assessing experiences with discrimination were entered in the second block.

For our second hypothesis, we predicted that experiences with microaggression would account for variance explained in BE, beyond dietary restraint, emotion dysregulation, and stress. A multiple regression was conducted with BE behavior as the outcome variable. Scores on measures assessing dietary restraint, emotion dysregulation, and perceived stress were entered in the first block. Scores on the measure assessing experiences with microaggressions were entered in the second block.

For our third hypothesis, we predicted that stress associated with microaggressions would account for variance explained in BE, beyond dietary restraint, emotion dysregulation, and perceived stress. A multiple regression was conducted with BE behavior as the outcome variable. Scores on measures assessing dietary restraint, emotion dysregulation, and perceived stress were entered in the first block. Scores on the measure assessing stress associated with experiences with microaggressions were entered in the second block.

Results

The mean and standard deviation for all measures can be found in Table 1. Correlations among measures are shown in Table 2. BE scores correlated statistically significantly with all measures: dietary restraint, perceived stress, emotion dysregulation, and experiences with discrimination and microaggressions (experiences and stress).

Hypothesis 1- Predicting BE from Experiences with Discrimination After Accounting for Known BE Predictors

Results of our first multiple regression found that dietary restraint, emotion dysregulation, and perceived stress accounted for a total of 44% variance in BE. Experiences with discrimination did not account for any additional significant portion of variance, $\beta = .054$, $t(177) = .715$, $p = .476$ (Table 3).

Hypothesis 2- Predicting BE from Experiences with Microaggressions After Accounting for BE Predictors

Results of our second multiple regression found that, collectively, dietary restraint, emotion dysregulation, and perceived stress accounted for 44% in BE. Experiences with microaggressions accounted for an additional 1% of variance in BE, $R^2 = .44$, $\Delta R^2 = .016$, $\Delta F(178) = 5.30$, $p = .022$ (Table 4).

Hypothesis 3- Predicting BE from Stress Associated with Microaggressions After Accounting for BE Predictors

Results of our third multiple regression found that collectively dietary restraint, emotion dysregulation, and perceived stress collectively accounted for 44% of variance in BE. Stress associated with experiences with microaggressions accounted for an additional 2% of variance in BE, $R^2 = .47$, $\Delta R^2 = .024$, $\Delta F(178) = 7.97$, $p = .005$ (Table 5).

Discussion

Research on BE suggests that BE is driven by dietary restraint [2–3], emotion dysregulation [39] and stress [5–7, 10]. Consequently, evidenced-based interventions for BE address and teach regular eating, and focus on developing skills to cope with emotion dysregulation and stress [13]. While little research in eating disorders centers the experience of Black women, research suggests that Black women engage in BE at higher rates compared to other racial and ethnic groups [40]. Yet, BE interventions are less effective among Black women likely because research in BE development, maintenance, and intervention has been influenced by and developed for White women [17, 21]. This calls into question the efficacy of BE theories, and potentially, BE interventions for Black women.

Racism related stress is a unique form of stress that has a negative psychological impact [23]. Discrimination and microaggressions are examples of racism related stress that leads to increased levels of stress and emotion dysregulation [27, 28]. While racism related stress is a form of stress, it is unique to marginalized people living in a majority population (i.e., Black Americans living in the United States). Racism related stress is also unique due to its pervasiveness because of the history of racial oppression in the United States [24–26]. Unfortunately, these unique experiences are rarely identified as factors impacting psychological well-being. Continued failure to address or acknowledge these experiences potentially dismisses a critical aspect of Black women's experiences and their mental health presentation. Taking it one step further, intervention modules that are not relevant to users' symptoms or risk profiles may lead to less motivation and attention, and ultimately dropout [40]. Therefore, this investigation examined the impact of discrimination and microaggressions on BE behaviors.

In support of previous research, results of this investigation found that dietary restraint, emotion dysregulation, and stress are significant predictors of BE behaviors. This study also found that experiences with microaggressions and stress associated with microaggressions (hereafter referred to as microaggressions) accounted for some variance in BE behaviors. However, results also indicated that experiences with discrimination did not account for any additional variance in BE behaviors. One potential explanation of these findings depends on a thorough understanding of microaggressions and their impact.

Microaggressions are defined as "subtle, stunning, often automatic, and non-verbal exchanges that are 'put downs'" [41 p. 66]. The significant impact they have on individuals lies in their invisibility while their complexity lies in their ability to be explained by other, supposedly, nonbiased rationale. Because microaggressions are generally more covert and occur on a less conscious level [42], they can lead to psychological dilemmas. Repeated exposures to microaggressions have demonstrated to impact one's ability to self-regulate [29, 31]. Based on Muraven & Baumeister [30] self-regulation model, self-regulation is a limited resource, and with each new encounter the ability for one to self-regulate decreases until an individual can rest and restore. Because microaggressions are insidious, they may require a higher level of self-regulation; depleting one's cognitive and emotional energy and therefore their ability to self-regulate with each encounter that follows. This may leave an individual susceptible to maladaptive

behaviors. For example, a comment to a Black woman that they are “so articulate” may on the surface seem innocuous but when considering the historical context of Black people being portrayed as less intelligent, this statement suggests a preconceived unconscious assumption that this woman is not intelligent because she is Black. But because this form of discrimination is not overt, a Black woman may spend time wondering and thinking about the interaction, and whether the individual was making this assumption. This mental game of “table tennis” requires cognitive and emotional self-regulation and due to the frequency of different forms of microaggressions (race and gender) Black women experience, it is hard for them to fully rest and restore their ability to self-regulate.

Decreased self-regulation impacts executive functioning, specifically behavioral inhibition. BE is one potential result of behavioral inhibition. Hagger et al., [43] demonstrated this in a study with 155 college students examining the impact of self-regulation on eating behaviors after completing a challenging task (counting down from 1000 by five). Results of this investigation found that the students who completed the cognitively demanding task consumed significantly more food during a taste-and-rate task compared to students who did not complete the task. These findings suggest that when self-regulation is depleted, individuals may be more susceptible to BE due to behavioral inhibition. A literature review conducted by Dohle et al., [44] further supports this theory. Their review concluded that executive functioning, specifically inhibition, plays a role in eating behaviors; suggesting that decreased self-regulation impacts inhibition, and therefore, making one more susceptible to BE episodes. The results of these studies help explain the findings of the current investigation. Experiences with microaggressions uniquely predict BE behaviors due to decreases in self-regulation. This decrease in self-regulation may result in BE behaviors explained by behavioral inhibition.

Consistent with previous research and theory, dietary restraint explained a majority of the variance in BE behavior in this sample. This was unexpected since extant research investigating dietary restraint in Black women has produced inconsistent results. Whereas some studies suggest that Black women do not engage in dietary restraint, other qualitative work suggest Black women do engage in dietary restraint but for different reasons than typically reported by White women (i.e., in pursuit of the thin-ideal). More specifically, some qualitative evidence suggests that Black women report engaging in dietary restraint to change their bodies for reasons related to body consciousness and body management (in hopes of averting negative experiences [45]. Similarly, Hughes [46] found that Black women existing in White dominated spaces noted that they believed they would be more successful if they had a thinner body. Based on these results we hypothesize that Black women may engage in dietary restraint due to experiences with discrimination. The results of this investigation found a correlation between dietary restraint and experiences with discrimination, which provides some support for our hypothesis. We must acknowledge, however, that the correlation was small to medium in size correlation, suggesting additional uniqueness that may not be captured with our current constructs and measures. This is not surprising since extent research has found that many of the measures used to assess disordered eating behavior have been created for and normed on White women. These findings further support the need to develop more culturally informed measures to accurately assess body image

and eating disorders among marginalized communities. Failing to do so will continue to result in inaccurate or limited findings, further increasing the health equity gap.

Limitations

Despite the important findings in the investigation, there are notable limitations. Data was collected through the platform of Qualtrics. While this platform allows anonymity and allows participants to complete the survey at a time and space convenient to them it also eliminates potential participants who do not have access to online platforms. Additionally, with the increase in the presence of AI bots may have gained access to the survey. Precautions were implemented, such as Captcha's and simple mathematical equations (i.e., 3 + 3) but bot responses may still be present in the data analyses. Finally, the theories addressed in this investigation were longitudinal but cross-sectional methodology was utilized. Future research should aim to investigate this theory longitudinally.

Conclusion

Dietary restraint [2–3], emotion dysregulation [40], and stress (5–7,10] are significant predictors of BE. This investigation supported this theory while also finding that common experiences for marginalized groups uniquely predict BE behaviors among Black women, yet current assessment is missing critical information. Based on these findings future research should continue to explore this relationship not by simply increasing diversity within samples (although this is still important) but redefining current constructs to reflect more diverse experiences, and therefore, needs.

Declarations

Ethics approval and consent to participate

All participants provided consent to participate. All participants were informed that participation in the study is both voluntary and anonymous. The study was monitored and approved by the IRB at the University of Missouri-Kansas City.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request

Competing interests

The authors declare that they have no competing interests.

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Authors' contribution

SW: Conceptualization, Formal analysis, Methodology, Writing—original draft.

CB: Resources, Supervision, Writing—review and editing. All authors read and approved the final manuscript.

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References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. American psychiatric association; 2013 May 22.
2. Polivy J, Heatherton TF, Herman CP. Self-esteem, restraint, and eating behavior. Journal of Abnormal Psychology. 1988 Aug;97(3):354.Nisbett, R. E. (1972). Hunger, obesity, and the ventromedial hypothalamus. *PsychologicalReview*, *79*(6), 433
3. Heatherton TF, Baumeister RF. Binge eating as escape from self-awareness. Psychological bulletin. 1991 Jul;110(1):86.
4. Goldfield GS, Mallory R, Parker T, Cunningham T, Legg C, Lumb A, Parker K, Prud'homme D, Adamo KB. Effects of modifying physical activity and sedentary behavior on psychosocial adjustment in overweight/obese children. Journal of pediatric psychology. 2007 Aug 1;32(7):783-93.
5. Groesz LM, McCoy S, Carl J, Saslow L, Stewart J, Adler N, Laraia B, Epel E. What is eating you? Stress and the drive to eat. Appetite. 2012 Apr 1;58(2):717-21.
6. Rosenbaum DL, White KS. The relation of anxiety, depression, and stress to binge eating behavior. Journal of health psychology. 2015 Jun;20(6):887-98.
7. Casari MA, Pires VP, Pureza IM, Busnello FM. Does Restriction Lead to Binge Eating? A Scoping Review on Restrictive Diets in the Development and Maintenance of Binge Eating Disorder. Nutrition Reviews. 2026 Jan;84(1):189-206.
8. Linardon J, Messer M, Shatte A, Skvarc D, Rosato J, Rathgen A, Fuller-Tyszkiewicz M. Targeting dietary restraint to reduce binge eating: A randomised controlled trial of a blended internet-and smartphone app-based intervention. Psychological Medicine. 2023 Mar;53(4):1277-87.
9. Schulz S, Laessle RG. Stress-induced laboratory eating behavior in obese women with binge eating disorder. Appetite. 2012 Apr 1;58(2):457-61.
10. Sultson H, Kreegipuu K, Akkermann K. Exploring the role of momentary positive and negative affect in overeating and binge eating: Evidence for different associations among men and women.

Appetite. 2022 Jan 1;168:105758.

11. Smith KE, Mason TB, Schaefer LM, Anderson LM, Critchley K, Crosby RD, Engel SG, Crow SJ, Wonderlich SA, Peterson CB. Dynamic stress responses and real-time symptoms in binge-eating disorder. Annals of Behavioral Medicine. 2021 Aug 21;55(8):758-68.
12. Fairburn CG. Cognitive behavior therapy and eating disorders. Guilford Press; 2008 Apr 21.
13. Kelly NR, Kosty D, Guerricabeitia L, Guidinger C, Williamson G. Evaluating components of existing theories for loss of control eating in a sample of young racially/ethnically diverse men. Body Image. 2020 Dec 1;35:63-70.
14. Stojek MM, Fischer S. Thinness expectancies and restraint in Black and White college women: A prospective study. Eating Behaviors. 2013 Aug 1;14(3):269-73.
15. Swanson SA, Crow SJ, Le Grange D, Swendsen J, Merikangas KR. Prevalence and correlates of eating disorders in adolescents: Results from the national comorbidity survey replication adolescent supplement. Archives of general psychiatry. 2011 Jul 4;68(7):714-23.
16. Goode RW, Kalarchian MA, Craighead L, Conroy MB, Wallace Jr J, Eack SM, Burke LE. The feasibility of a binge eating intervention in Black women with obesity. Eating Behaviors. 2018 Apr 1;29:83-90.
17. Pike KM, Dohm FA, Striegel-Moore RH, Wilfley DE, Fairburn CG. A comparison of black and white women with binge eating disorder. American Journal of Psychiatry. 2001 Sep 1;158(9):1455-60.
18. Scott, T. N., Gil-Rivas, V., & Cachelin, F. M. (2019). The need for cultural adaptations to health interventions for African American women: A qualitative analysis. *Cultural Diversity & Ethnic Minority Psychology*, *25*(3), 331.
19. Thompson-Brenner H, Franko DL, Thompson DR, Grilo CM, Boisseau CL, Roehrig JP, Richards LK, Bryson SW, Bulik CM, Crow SJ, Devlin MJ. Race/ethnicity, education, and treatment parameters as moderators and predictors of outcome in binge eating disorder. Journal of consulting and clinical psychology. 2013 Aug;81(4):710.
20. Goode RW, Cowell MM, Mazzeo SE, Cooper-Lewter C, Forte A, Olayia OI, Bulik CM. Binge eating and binge-eating disorder in Black women: A systematic review. International Journal of Eating Disorders. 2020 Apr;53(4):491-507.
21. Crenshaw KW. Mapping the margins: Intersectionality, identity politics, and violence against women of color. In trhe public nature of private violence 2013 Feb 1 (pp. 93-118). Routledge.
22. Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans: A biopsychosocial model. American psychologist. 1999 Oct;54(10):805.
23. Meyer IH. Minority stress and mental health in gay men. Journal of health and social behavior. 1995 Mar 1:38-56.
24. Smith WA, Allen WR, Danley LL. “Assume the position... you fit the description” psychosocial experiences and racial battle fatigue among African American male college students. American Behavioral Scientist. 2007 Dec;51(4):551-78.

25. Smith WA, Hung M, Franklin JD. Racial battle fatigue and the miseducation of Black men: Racial microaggressions, societal problems, and environmental stress. Journal of Negro Education. 2011;80(1):63-82.
26. Joseph NT, Peterson LM, Gordon H, Kamarck TW. The double burden of racial discrimination in daily-life moments: Increases in negative emotions and depletion of psychosocial resources among emerging adult African Americans. Cultural Diversity & Ethnic Minority Psychology. 2021 Apr;27(2):234.
27. Bravo AJ, Wedell E, Villarosa-Hurlocker MC, Looby A, Dickter CL, Schepis TS, Stimulant Norms and Prevalence (SNAP) Study Team. Perceived racial/ethnic discrimination among young adult college students: Prevalence rates and associations with mental health. Journal of American college health. 2023 Sep 2;71(7):2062-73.
28. Banks BM, Landau SE. Cognitive effects of racial microaggressions directed at Black college women. Journal of Negro Education. 2021;90(1):84-95.
29. Muraven M, Baumeister RF. Self-regulation and depletion of limited resources: Does self-control resemble a muscle?. Psychological bulletin. 2000 Mar;126(2):247.
30. Muraven M, Tice DM, Baumeister RF. Self-control as a limited resource: regulatory depletion patterns. Journal of personality and social psychology. 1998 Mar;74(3):774.
31. Franklin AJ. The invisibility syndrome. In the use of personal narratives in the helping professions 2014 Jan 2 (pp. 121-130). Routledge.
32. Assari S. Perceived discrimination and binge eating disorder; gender difference in African Americans. Journal of Clinical Medicine. 2018 Apr 24;7(5):89.
33. Fairburn CG, Beglin SJ. Eating disorder examination questionnaire. Cognitive behavior therapy and eating disorders. 2008 Sep;309(313):509-28.
34. Gormally JI, Black S, Daston S, Rardin D. The assessment of binge eating severity among obese persons. Addictive behaviors. 1982 Jan 1;7(1):47-55.
35. Cohen S. Perceived stress in a probability sample of the United States.
36. Kaufman EA, Xia M, Fosco G, Yaptangco M, Skidmore CR, Crowell SE. The Difficulties in Emotion Regulation Scale Short Form (DERS-SF): Validation and replication in adolescent and adult samples. Journal of psychopathology and behavioral assessment. 2016 Sep;38(3):443-55.
37. Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: Socio-economic status, stress and discrimination. Journal of health psychology. 1997 Jul;2(3):335-51.
38. Torres-Harding SR, Andrade Jr AL, Romero Diaz CE. The Racial Microaggressions Scale (RMAS): a new scale to measure experiences of racial microaggressions in people of color. Cultural Diversity & Ethnic Minority Psychology. 2012 Apr;18(2):153.
39. Bruch H. Psychiatric aspects of obesity. Psychiatric Annals. 1973 Jul 1;3(7):6-9.

40. Goode RW, Webster CK, Gwira RE. A review of binge-eating disorder in black women: treatment recommendations and implications for healthcare providers. Current psychiatry reports. 2022 Dec;24(12):757-66.
41. Pierce CM, Carew JV, Pierce-Gonzalez D, Wills D. An experiment in racism: TV commercials. Education and Urban Society. 1977 Nov;10(1):61-87.
42. Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder A, Nadal KL, Esquilin M. Racial microaggressions in everyday life: implications for clinical practice. American psychologist. 2007 May;62(4):271.
43. Hagger MS, Panetta G, Leung CM, Wong GG, Wang JC, Chan DK, Keatley DA, Chatzisarantis NL. Chronic inhibition, self-control and eating behavior: Test of a 'resource depletion'model. PloS one. 2013 Oct 17;8(10):e76888.
44. Dohle S, Diel K, Hofmann W. Executive functions and the self-regulation of eating behavior: A review. Appetite. 2018 May 1;124:4-9.
45. Kwan S. Navigating public spaces: Gender, race, and body privilege in everyday life. Feminist formations. 2010;22(2):144-66.
46. Hughes, E., 2021. "I'm supposed to be thick": managing body image anxieties among Black American women. *Journal of Black Studies*, *52*(3), pp.310-330.

Tables

Table 1 *Means and Standard Deviations of Measures*

	Total Sample (*N*=197)	
Measure	*M*	*SD*
Eating Behaviors		
EDE-Q		
Restraint	1.10	1.14
Global Score	1.31	.98
Gormally Binge Eating Scale	11.43	9.68
Emotion Dysregulation and Stress		
DERS-Aware	9.07	2.32
DERS-Clarity	5.59	2.27
DERS-Goals	6.76	2.50
DERS-Impulse	6.12	2.34
DERS-NonAccept	6.47	2.29
DERS-Strategies	6.27	2.35
DERS-SF	40.37	10.74
PSS	16.79	5.79
Microaggressions and Discrimination		

RMAS-For	2.57	2.39
RMAS-For-Stress	2.29	2.57
RMAS-Crim	2.81	2.58
RMAS-Crim-Stress	3.13	3.21
RMAS-Sex	2.54	2.47
RMAS-Sex-Stress	2.04	2.83
RMAS-Low	11.46	6.72
RMAS-Low-Stress	10.89	7.49
RMAS-Inv	7.29	5.73
RMAS-Inv-Stress	8.14	6.68
RMAS-Env	6.46	4.68
RMAS-Env-Stress	4.92	4.42
RMAS-Total	33.15	19.93
RMAS-Stress	31.43	22.49

						22.69	7.86
EDS							

Note. EDE-Q Eating Disorder Examination Questionnaire, DERS- Difficulties with Emotion Regulation Scale, DERS-Aware- Lack of emotional awareness, DERS-Clarity- Lack of emotional clarity, DERS-Goals – Difficulty engaging in goal directed behavior, DERS-Impulse – Impulse control difficulties, DERS-NonAccept – Nonacceptance of emotional responses, DERS-Strategies – Limited access to emotion regulation strategies, PSS- Perceived Stress Scale, EDS- Everyday Discrimination Scale, RMAS- Racial Microaggressions Scale, RMAS-For – Foreigner/ not belonging, RMAS-For-Stress – Stress associated with foreigner/not belonging, RMAS-Crim-Criminality/assumption of criminal status, RMAS-Crime-Stress – Stress associated with Criminality/assumption of criminal status, RMAS-Sex - Sexualization, RMAS-Sex-Stress- Stress associated with Sexualization, RMAS-Low - Low achieving/undesirable culture, RMAS-Low-Stress – Stress associated with low achieving/undesirable culture, RMAS_Inv – Invisibility, RMAS-Inv-Stress – Stress associated with Invisibility, RMAS-Env- Environmental Invalidation, RMAS-Env-Stress - Stress associated with Environmental Invalidation, RMAS-Stress – Stress associated with Microaggressions

Table 2 *Variable Correlations*

Variable	1	2	3	4	5	6	7
1. BES	--	--	--	--	--	--	--
2. EDE-Q Restraint	**.490****	--	--	--	--	--	--
3. DERS-SF	**.458****	-.005	--	--	--	--	--
4. PSS	**.284****	.071	**.536****	--	--	--	--
5. EDS	**.282****	**.241****	**.216****	**.278****	--	--	--
6. RMAS-Total	**.270****	**.200****	.047	**.139***	**.675****	--	--
7. RMAS-Stress	**.327****	**.207****	**.141***	**.221****	**.679****	**.878****	--

Note. EDE-Q- Eating Disorder Examination Questionnaire, Restraint Subscale, DERS- Difficulties with Emotion Regulation Scale, PSS- Perceived Stress Scale, EDS- Everyday Discrimination Scale, RMAS-Racial Microaggressions Scale, RMAS-Stress – Stress associated with Racial Microaggressions Scale

Table 3 Experiences with Discrimination as Unique Predictor

Model		Sum of Squares	df	Mean Square	F	Sig
1	Regression	7281.976	6	1213.663	24.153	<.001[a]
	Residual	8944.240	178	50.249		
	Total	16226.216	184			
2	Regression	7307.216	7	1043.958	20.719	<.001[b]
	Residual	8918.509	177	50.387		
	Total	16226.216	184			

Note.

a. Predictors: (Constant), EDE-Q_Restraint, DERS-SF, PSS

b. Predictors: (Constant), EDE-Q_ Restraint, DERS-SF, PSS, EDS

Model Summary							
Model	R	R Square	Adjusted R Square	Std. Error of the estimate	R Square Change	F Change	Sig F Change
1	.670	.449	.430	7.089	.444	47.806	<.001
2	.671	.450	.429	7.098	.002	.511	.476

Note.

a. Predictors: (Constant), EDE-Q_ Restraint, DERS-SF, PSS

b. Predictors: (Constant), EDE-Q_ Restraint, DERS-SF, PSS, EDS

Table 4

Experiences with Microaggressions as Unique Predictor

Model		Sum of Squares	df	Mean Square	F	Sig
1	Regression	7288.859	6	1214.810	24.136	<.001[a]
	Residual	9009.448	179	50.332		
	Total	16298.306	185			
2	Regression	7549.430	7	1078.490	21.942	<.001[b]
	Residual	8748.876	178	49.151		
	Total	16298.306	185			

Note.

a. Predictors: (Constant), EDE_ Restraint, DERS-SF, PSS

b. Predictors: (Constant), EDE_ Restraint, DERS-SF, PSS, RMAS_Total

Model Summary							
Model	R	R Square	Adjusted R Square	Std. Error of the estimate	R Square Change	F Change	Sig F Change
1	.669	.447	.429	7.095	.442	47.705	<.001
2	.681	.463	.442	7.011	.016	5.301	.022

Note.

a. Predictors: (Constant), EDE-Q_ Restraint, DERS-SF, PSS

b. Predictors: (Constant), EDE-Q_ Restraint, DERS-SF PSS, RMAS_Total

Table 5 Stress Associated with Microaggressions as a Predictor

Model		Sum of Squares	df	Mean Square	F	Sig
1	Regression	7288.859	6	1214.810	24.136	<.001[a]
	Residual	9009.448	179	50.332		
	Total	16298.306	185			
2	Regression	7675.097	7	1096.442	22.633	<.001[b]
	Residual	8623.209	178	48.445		
	Total	16298.306	185			

Note.

a. Predictors: (Constant), EDE_ Restraint, DERS_Total, PSS_Global

b. Predictors: (Constant), EDE_ Restraint, DERS_Total, PSS_Global, RMAS_Stress

Model Summary							
Model	R	R Square	Adjusted R Square	Std. Error of the estimate	R Square Change	F Change	Sig F Change
1	.669	.447	.429	7.095	.442	47.705	<.001
2	.686	.471	.450	6.960	.024	7.973	.005

Note.

a. Predictors: (Constant), EDE_ Restraint, DERS-SF, PSS

b. Predictors: (Constant), EDE_ Restraint, DERS-SF, PSS RMAS_Stress