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Kristin Amy Swenson

Race and Diagnosis: An  
Assessment of Clinician  
Detection of Eating Disorder  
Symptomatology in Asian,  
African-American, and White  
Women

## ABSTRACT

The purpose of this mixed-methods study was to further explore the effect of race on clinicians' recognition of eating disorder symptomatology in Asian, African-American, and White women. This study replicated the work of Gordon, Brattole, Wingate, and Joiner (2006) in an attempt to re-affirm or challenge previous research findings found by Gordon et al., 2006, which suggest that clinicians identify eating disorder symptoms in White women more frequently than in African American women. The present study expanded Gordon et al.'s (2006) work by assessing clinicians' identification of eating disorder symptoms in Asian women and by examining themes in the qualitative portion of the narrative. The study explored the following question: Does a client's race impact clinicians' identification of eating disorder symptoms? It was hypothesized that clinicians are less likely to identify eating disorder symptoms in Asian and African American women than in White women and that clinicians would rate the severity of eating disorder symptoms similarly across racial groups.

Thirty-four clinicians trained in the field of Social Work participated in this study. Data was collected using the Drive for Thinness subscale of the Eating Disorder Inventory 3-RF (Garner, 2005) and the narrative portion of a case vignette describing the

symptoms of Mary, a 16 year old Asian, African American, or White female (Gordon et al., 2006).

Quantitative findings from the present study challenge the findings of Gordon et al. (2006) by suggesting that race does not significantly impact clinicians' identification of eating disorder symptomatology. Analyses of qualitative data suggest that race impacts the language used by clinicians to describe eating disorder symptomatology and is often reflective of racial stereotypes. An examination of the findings as they compare to previous literature and a discussion of language use in diagnoses were explored. Implications for social work practice were discussed.

RACE AND DIAGNOSIS: AN ASSESSMENT OF CLINICIAN DETECTION OF  
EATING DISORDER SYMPTOMATOLOGY IN ASIAN, AFRICAN AMERICAN,  
AND WHITE WOMEN

A study based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work

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2009

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## CHAPTER I

### INTRODUCTION

Historically, eating disorders have been conceptualized as a disease affecting White, upper-middle class women in Western cultures (Haworth-Hoepfner, 2000; Perez & Joiner, 2003; Root, 1990; Striegel-Moore & Smolak, 2000). This conceptualization developed out of research that, until recently, omitted women of color. The omission of women of color from eating disorders research has implications for theory development, treatment, and diagnoses. Specifically, theories suggesting that women of color suffer from eating disorders at lower rates than white women may lead to race related biases in diagnoses, ultimately impacting the rate at which women of color are diagnosed with eating disorders. While research has since expanded to include experiences of women of color, it is imperative to understand the impact of early discussions about eating disorders on the rate at which clinicians recognize symptoms. While previous research suggests that beliefs about the rate at which women of color experience eating disorders influences diagnoses (Gordon, Perez, and Joiner, 2002), new information about the presence of eating disorders in women of color gives reason for an examination of the diagnostic process today. In this way, the present mixed-methods study explores the following question: Does a client's race impact clinicians' identification of eating disorder symptoms?

The present mixed-methods study replicates the work of Gordon, Brattole, Wingate, and Joiner (2006) in an attempt to re-affirm or challenge previous research



findings (Gordon et al., 2006), which suggest that clinicians identify eating disorder symptoms in White women at higher rates than in African American women. In addition to exploring the rate at which clinicians identify eating disorders symptoms in African American women, this research expands Gordon et al.'s (2006) work by assessing clinicians' identification of eating disorder symptomatology in Asian women and by examining themes in the qualitative portion of the narrative. The purpose of this change is to determine whether clinicians identify eating disorder symptoms in Asian women at differing rates than in African American and White women and to further assess the information provided in the narrative about the diagnostic process.

A fixed methods design was used for this study. The purpose of using a mixed-method, experimental design for this research was to control for differential diagnoses based on symptom presentation and to assess for race related biases. By developing an understanding of current biases or lack thereof, findings from the present study will lead to the expansion of culturally sensitive training for social workers and more accurate diagnoses of eating disorders in various ethnic groups.

Phinney (1996) defined an ethnic group as "populations in the United States who are members of nondominant groups of non-European descent" (Phinney, 1996, as cited by Striegel-Moore & Smolak, 2002, p. 113). The following chapters will focus on the diagnostic process for women who identify their racial and/or ethnic background as African-American and Asian. It is important to note, however, that disordered eating patterns vary among and within ethnic groups. Thus, it is imperative that culturally sensitive treatment recognize these differences.

## CHAPTER II

### LITERATURE REVIEW

Eating disorders are a major health concern today, as they “are among the top four leading causes of burden of disease through death or disability” (Eating Disorders Coalition, 2008). In women ages 15 to 19, Anorexia Nervosa "is estimated to be the third most common chronic medical illness" (Lucas, Beard, O'Fallon, & Kurland, 1991, as cited by Garner, 2004, p. 2). Despite the health risks associated with eating disorders and the number of individuals who are impacted by these disorders, perceptions about eating disorders often assume that White women are impacted at higher rates than women of color. While research is inconclusive about the number of women of color who suffer from eating disorders, it is clear that women of color are not immune from these disorders (Gordon et al., 2006). Thus, it is imperative to further explore clinicians' detection of eating disorder symptoms across ethnic groups to see if race-based perceptions about eating disorders continue to impact clinicians' identification of eating disorder symptomatology.

Our understanding about the etiology of eating disorders was developed through early published research and beginning treatment of eating disorders by clinicians in treatment centers. Early research on eating disorders, which led to the development of models of eating disorder etiology, was conducted on White women while omitting the experiences of women of color. While current research has expanded to better understand the cultural, individual, and familial factors that contribute to the expression

of eating disorder symptomatology (Garner, 2004), perceptions about eating disorders in women of color appear to remain unchanged in some contexts. In this way, some research exploring eating disorders in women of color suggests that African American women are “protected” from eating disorders and Asian American women have a low incidence of eating disorders (Nicdao, Hong, & Takeuchi, 2007, Frisby, 2004; Perez & Joiner, 2003; Rosenburg, 1975 as cited by Root, 1990, p. 527).

Contradictory research questions the commonly held belief that White women suffer from eating disorders at higher rates than women of color by suggesting that the prevalence of eating disorders in women of color may be underestimated (Shaw, Ramirez, Trost, Randall, and Stice, 2004). Furthermore, findings from research indicate that Hispanic and Native American women suffer at higher rates than White women (Croll, Neumark-Sztainer, Story, & Ireland, 2003). Additional research looking at the eating disorder symptomatology in Chinese women found that rates of eating disorder symptoms were similar, if not greater, than rates of symptoms in English women (Kok & Tian, 1994 & S. Lee & Lee, 2000, as cited by Cummins, Simmons, & Zane, 2005, p. 556). Thus, it is clear that women of color are significantly impacted by eating disorders.

While research exploring eating disorders in women of color has expanded, theories developed out of research that omitted women of color or that asserted that African American women are “protected” from eating disorders may lead to race related biases in clinicians' identification of eating disorder symptomatology (Frisby, 2004; Perez & Joiner, 2003; Rosenburg, 1975 as cited by Root, 1990, p. 527). Race related biases in eating disorder symptom recognition were identified in research conducted by Gordon et al. (2006). Gordon et al. (2006) found that clinicians were less likely to detect eating

disorder symptoms in African American women than in Hispanic or White women. While Gordon et al.'s (2006) research reveals that overlooking eating disorder symptoms in African American women is common, Root (1990) suggests further challenges for women of color who have been diagnosed with eating disorders. Root (1990) states that many women of color, who are later diagnosed with eating disorders, suffer from the disorder for an extended period of time before accurate assessment is made. Because research shows that early detection and treatment of eating disorders leads to a greater likelihood of recovery, delayed diagnoses in women of color compromises treatment (D'Souza, Forman, & Austin, 2005). Thus, it is imperative to explore the diagnostic process for eating disorders to support understanding about the barriers that may remain in accurately assessing women of color.

The following review of literature explores race related biases and the impact of these biases on symptom detection in persons of color. The review also investigates the current definition of eating disorders and suggests that expanding this definition to include alternative presentations of eating disorders may support accurate diagnoses in women of color. Furthermore, the review of literature looks at the lens in which eating disorders have been conceptualized to emphasize the need to re-conceptualize this lens to more accurately diagnose women of color. Lastly, this review focuses on the factors identified as contributing to the development of eating disorders in white women and women of color revealing how commonly held beliefs about eating disorders lead to biases in diagnoses.

### *Race and Biases*

Race related bias refers to the prejudgment of an individual based on race (Lopez, 1989). Theoretical biases present in the mental health field are influenced by the fact that counseling in the United States is “founded on values, expectations, and beliefs derived from European psychologists and White practitioners in this country” (Miller & Garran, 2008, p. 76). Eating disorder treatment has been influenced by the experiences and training of clinicians working with White women, as much of the early research and training about eating disorders included the experiences of White women while omitting women of color. In this way, eating disorder research founded on the needs of White clients leads to theoretical biases within the field and possible misconceptions about the impact of eating disorders in women of color.

Clinicians develop biases from information, values, and constraints in personal, professional, institutional, and social contexts (Poland & Caplan, 2004). Biases constructed from these contexts influence interactions in the clinical dyad. Clinicians may enact these biases in many ways. For example, clinicians may exhibit bias by valuing certain information over other information and/or by judging a client from an ethnic group as suffering from a mental illness more or less readily than a client from a different ethnic group (Poland & Caplan, 2004).

Race related bias has been studied in research looking at diagnoses of psychoses (Blow, Zeber, McCarthy, Valenstein, Gillon, & Bingham, 2004) and in Gordon et al.’s (2006) research on eating disorders. Findings from both studies suggest that race related biases are present in the diagnostic process (Blow et al., 2004; Gordon et al., 2006). Blow et al. (2004) analyzed data obtained from the National Psychosis Registry for

patients who had been diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder. After assessing for differences in symptom presentation, a multi-nominal, logistic regression was used to assess the probability of diagnoses of schizophrenia, schizoaffective disorder, or bipolar disorder based on race. Findings reveal that individuals of color were more likely than White patients to receive a diagnosis of schizophrenia (Blow et al., 2004).

In Gordon et al.'s (2006) work, clinicians were presented with the story of Mary, a sixteen year old female whose race was identified as African American, Hispanic, or White, but whose symptom presentation remained the same. Gordon et al. (2006) found that, while Mary's symptoms did not change, clinicians detected Mary's eating disorder symptoms at different rates based on her race. As mentioned earlier in the chapter, findings reveal that clinicians were less likely to recognize eating disorder symptoms in African American women than in White and Hispanic women. In both studies, clients of color and White clients presented with the same symptoms, revealing that symptom recognition was impacted by biases and not symptom presentation. In line with Gordon et al.'s (2006) research, participants in the present study were presented with the same symptom profile for Mary, whose race was changed to African American, White, or Asian. The purpose of keeping Mary's symptoms consistent throughout the case studies, while changing her race, was to control for differential diagnoses based on symptom presentation.

Biases based on racial stereotypes may influence the likelihood of race related disparities in diagnoses. Researchers attribute the racial stereotype that African American men are prone to violence to the over-diagnoses of African American men with

paranoid schizophrenia (Loring & Powell, 1988, as cited by Whaley, 2004, p. 78).

Furthermore, theories suggesting that African American women are "protected" from eating disorders, which are consistent with stereotypes that African American women have larger body image ideals, may influence the under-diagnoses of eating disorders in African American women. Stereotypes also may influence the under-diagnoses of eating disorders in Asian women. Stereotypes suggesting that Asian women have thin physiques may cause clinicians to attribute Asian client's thinness to genetics rather than to eating disorders (Haynie, 2009).

The impact of stereotypes on eating disorder symptom recognition was examined by Gordon, Perez, and Joiner (2002). In the study (Gordon et al., 2002), one hundred and sixty undergraduate students were asked to read a journal entry describing the eating patterns and school related activities of Mary, a 16 year old African American, Hispanic, or White female. Participants filled out the Eating Disorder Inventory (Garner, Olmstead, & Polivy, 1983) from the perspective of Mary to assess the severity of Mary's symptoms and answered the open-ended question: "Do you think Mary has any problems and, if so, what are they?". Findings indicate that stereotypes influence eating disorder symptom recognition, as participants identified eating disorder symptoms in Mary when she identified as White more frequently than when she identified as Hispanic or African American. Additionally, participants discounted specific symptom information when Mary identified as Hispanic or African American, but discussed these symptoms when she identified as White. Gordon et al.'s (2002) findings suggest that beliefs about the likelihood of eating disorder symptomatology in various ethnic groups impact eating disorder symptom recognition in women of color (Gordon et al., 2002). In this way,

expanding information about eating disorders in women of color that combat racial stereotypes may lead to more culturally sensitive diagnoses.

It is important to assess race related biases in the diagnostic process, as race related biases also impact access to treatment for individuals with eating disorder symptoms. Becker, Franko, Speck, and Herzog (2002) assessed the impact of ethnicity on access to eating disorder treatment. The researchers' analyzed data collected from self-reported questionnaires, clinicians' recommendations for further treatment, and conversations from telephone interviews with clients originally surveyed (Becker et al., 2002). Findings from the study indicate that Latino and Native American participants were significantly less likely to receive further treatment for eating disorders than their White counterparts (Becker et al., 2002). Thus, clinicians' bias about the likelihood of eating disorders in clients of color appears to influence future access to treatment. In this way, the diagnostic process needs to be examined further in an effort to improve treatment for persons of color.

While biases take many forms including that of gender, social class, race, age, and ableism, the present mixed-methods study will focus on biases related to race as it impacts eating disorder symptom recognition in women of color by clinicians from clinical Social Work backgrounds. The present study will examine the impact of race on symptom recognition by exploring the following question: Does a client's race impact clinicians' identification of eating disorder symptoms? The present study replicates Gordon et al.'s (2006) work to assess if race related bias continues to impact eating disorder symptom recognition today. The present study will expand Gordon et al.'s



(2006) work by assessing clinicians' identification of eating disorder symptoms in Asian women and by examining themes in the qualitative portion of the narrative.

### *Definition and Presentation of Eating Disorders*

For the purpose of this study, the characteristics of eating disorders are defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV TR, 2000). Anorexia nervosa is defined by the "refusal to maintain a weight above a minimally normal level for age and height" (Striegel-Moore & Smolak, 2000, p. 232). Anorexia nervosa is characterized by a fear of gaining weight, body image disturbance, and amenorrhea (DSM-IV TR, 2000). Methods of controlling weight include restricting eating or purging (DSM-IV TR, 2000). Binge eating disorder is defined by "reoccurring episodes of binge eating" in the absence of behaviors to compensate for binge eating (Striegel-Moore & Smolak, 2000, p. 232). Bulimia nervosa involves recurrent binge eating and "extreme behaviors to control weight, and body image disturbance" (Striegel-Moore & Smolak, 2000, p. 232). Behaviors to control weight include self-induced vomiting and/or the misuse of laxatives, diuretics, enemas, and other medication (DSM-IV TR, 2000).

Misdiagnosis of mental health issues in various ethnic groups has led some critics to examine the criteria used to assess mental health disorders. Franko (2007) suggests that the definitions of eating disorders need to be more culturally sensitive, as individuals in various ethnic groups may not meet the current diagnostic criteria for eating disorders leading to the under-diagnosis of women of color. While the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, is one of the primary diagnostic tools used by clinicians to diagnose mental disorders, the tool has been

challenged about its ability to represent varying presentations of eating disorders (Garner, 2004). Diagnostic criteria may also influence clinicians' understanding of the presentations of mental health disorders leading to the assumption that different ethnic groups express symptoms similarly (Whaley, 1997).

Cummins, Simmons, and Zane (2005) suggest that individuals from various ethnic groups who suffer from eating disorders may express eating disorder symptoms differently (p. 555). For example, body image disturbances, a symptom believed to impact eating disorders, may not always be present in patients with eating disorders from various ethnic groups. In a case study exploring eating disorders in patients in India, findings suggest that body image disturbances were less likely to be present than body image disturbances in Western counterparts (Khandelwal & Saxena, 1990, as cited in Cummins, Simmons & Zane, 2005, p. 558). Findings from research looking at eating disorder symptomatology in Chinese patients suggest that body image symptoms may be less common in Chinese patients than in Western patients (Lai, Pang, & Wong, 1995, as cited in Cummins, Simmons & Zane, 2005, p. 558). Despite varying symptom presentations, rates of eating disorder symptoms in South East Asian populations are similar or greater than rates of eating disorder symptoms in Western populations (Cummins, Simmons, & Zane, 2005).

While expanded knowledge of alternative presentations of eating disorders may support more accurate diagnoses, race related biases appear to impact diagnoses regardless of symptom presentation (Gordon et al., 2006). This suggests that that misdiagnoses of eating disorders in women of color appears not to be the result of

differences in symptom presentation, but rather reflective of clinicians' beliefs about the prevalence of eating disorders in various ethnic groups.

### *Contextual Lens*

Sociocultural models of eating disorders emphasize that cultural influences impact body image disturbances and eating disorders. Thus, it can be hypothesized that the factors that influence eating disorders vary among ethnic groups (Striegel-Moore & Smolak, 2000). The importance of understanding these factors from a cultural context is emphasized by Crago, Shisslak, and Estes (1996). Crago et al. (1996) state that while “eating disorder symptoms appear similar across cultures, the context in which an eating disorder develops, the purpose it serves, and what constitutes an effective intervention is different” (p. 240). In this way, clinicians' misunderstanding of cultural norms may lead to the misdiagnosis of mental health disorders in persons of color. Whaley (1997) suggests that the misunderstanding of cultural norms may contribute to the over-diagnosis of schizophrenia in African American clients. Whaley (1997) states that, while it is appropriate for African American clients to experience "cultural paranoia," a healthy, adaptive response to racism and oppression in society, clinicians may misconstrue this adaptive response as a symptom of mental illness (p.4). Thus, clinicians' interpretation of symptoms impacts the diagnostic process and treatment recommendations.

Lee and Lock (2007) assessed the clinical characteristics of eating disorders in Asian American adolescents. Findings from this study suggest that the meaning of the eating disorder symptoms appear to be different in Asian American adolescents. For example, Asian American women did not attribute their refusal to eat to a phobia of fat, but rather to a loss of appetite and bloating (Lee & Lock, 2007). This may impact

clinical diagnoses of eating disorders in Asian women because diagnostic criteria suggest that the meaning behind restricting caloric intake is a fat phobia. It appears that, for Asian American adolescents, restricting caloric intake may not be attributed to a fear of fat because losing fat was not the issue, because of cultural norms that delegitimize phobias, or because fat concerns were being denied (Lee & Lock, 2007).

Root (1990) states that “the limitations of current theory and discussion of who is vulnerable to developing an eating disorder reflects racial/ethnic stereotyping, Western Eurocentrism, and the lack of experience of mainstream researchers in working with a diversity of people” (Root, 1990, p. 526). Root’s (1990) statement emphasizes the need to understand the cultural factors impacting eating disorder development in an effort to support accurate diagnoses that does not reflect ethnic stereotyping and that takes into consideration the various meanings of symptoms across ethnic groups. Thus, it is imperative that we understand the lens from which information is presented to understand how symptoms of eating disorders are understood. Because prior information about eating disorders often negates the contextual factors involved in the development of eating disorders in women of color, eating disorders in women of color may be misunderstood and misdiagnosed. At the same time, new information about factors influencing eating disorders in women of color has been introduced. Thus, it is necessary to define the current state of symptom recognition to understand how current information impacts diagnoses today.

## *Contextual Components and bias*

### *Factors contributing to Eating Disorders*

Empirical findings suggest that eating disorders in white women and women of color are influenced by the following factors: “sociocultural context (including thin beauty ideals, gender roles), familial and interpersonal context (family dynamics, peer influences), personal vulnerability factors (genetic factors, personality traits, behaviors) and traumatic life events (physical or sexual abuse)” (Striegel-Moore & Cachelin, 2001, p. 641). While research looking at the etiology of eating disorders has expanded to include the role of culture in expression of eating disorders, models developed out of early research suggest that individual, familial, and sociocultural risk factors (growing up female, living in Western society, adolescence or early adulthood, low self-esteem, perfectionism, depression, and family history of an eating disorder, depression, or substance abuse) contribute to the development of an eating disorder (Garner, 2004). While the factors described above are thought to influence eating disorders in all women regardless of race, the application of these factors on women of color needs to be explored further, as the factors above are rooted in research that originally omitted women of color.

Haworth-Hoepfner (2000) suggests that cultural messages “take on different meanings or value as they are interpreted through different family groups” (Haworth-Hoepfner, 2000, p.214). Because these factors are applied to eating disorder symptomatology similarly across ethnic groups, without understanding the cultural context for women of color, clinicians may be misguided about who is “protected” from an eating disorder and who is not. While eating disorder research has begun to examine

eating disorders in women of color, discussions of findings often reveal differences, yet display insensitivity to the cultural, social, or psychological meaning behind the differences.

Research about eating disorders in African American women conducted from this framework suggests that African American women are “protected” from eating disorders based on findings that conclude that African American women have “better self-images, high self-esteem, greater emotional stability, and less self-consciousness than their White peers” (all variables thought to influence eating disorders in White women) (Rosenburg, 1975 as cited by Root, 1990, p. 527; Striegel-Moore & Smolak, 2000). Research suggesting that women of color are “protected” from eating disorders appears to negate the influence of beauty ideals on women of color.

The impact of cultural influences on bulimic symptoms in various ethnic groups was explored by Perez and Joiner (2003). Perez and Joiner (2003) measured individuals' perceived body image and ideal body image using the Stunkard Body Figure Scale (Stunkard, Sorenson & Schlusinger, 1983). To measure symptoms of disordered eating and patterns of thinking, the researchers used eight subscales (drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interceptive awareness, and maturity fears) from the Eating Disorders Inventory (Garner, 1987). Results indicated that both African American and White women, who perceived their bodies as differing from the ideal body size of their ethnic group, reported bulimic symptoms (Perez & Joiner, 2003).

Frisby (2004) looked at the impact of idealized images in advertising on body dissatisfaction in women of color. Frisby (2004) hypothesized that African American

women would compare themselves to other women of color in advertisements, but would not compare themselves to White women. Frisby (2004) found that African American women were impacted by women of color in advertisements if they experienced body dissatisfaction. Findings from Frisby's (2004) work reveal that, despite being impacted by other women of color, African American women's self-esteem was not impacted by exposure to advertisements depicting White women. Findings from both studies reveal that, while African American and White women are influenced by ideal body size, body dissatisfaction in African American women appears to be influenced by the similarities between one's perceived body image and the perceived ideal of other African American women. In this way, the meaning of beauty ideals in African American women, the impact of these ideals on one's sense of self, and the impact of beauty ideals on the development of an eating disorder, may be overlooked when assumptions about the protective role of larger body image in African American women is made.

#### *Factors influencing women of color*

Research exploring the experiences of women of color found additional factors that contribute to eating disorders in various ethnic groups (Iyer & Haslam, 2003; Kuba & Harris, 2001; Thompson, 1992). Findings suggest that women of color are impacted by family structure, racial teasing, oppression, and trauma (Iyer & Haslam, 2003; Kuba & Harris, 2001; Thompson, 1992). Further findings suggest that women of color may be impacted by acculturation (Perez, Voelez, Pettit, & Joiner, 2002); however, these findings have been challenged by contradictory research questioning the impact of acculturation (Jennings, Forbes, McDermott, and Hulse, 2006).

Iyer and Haslam (2003) investigated the role of teasing about racial/ethnic features in developing eating disturbances in women of South Asian descent. A sample of college-aged women of South Asian descent filled out measures assessing levels of "disturbed eating behavior, body image dissatisfaction, distress, self-esteem, acculturation, ethnic identification, and racial teasing" (Iyer & Haslam, 2003, p. 142). Findings indicate that racial teasing was correlated with disturbed eating and body image among women in the sample (Iyer & Haslam, 2003).

Additional research by Thompson (1992) examined how systems of oppression influence eating disorders in women of color. Thompson (1992) interviewed women of color to explore the impact of oppression on the development of eating disorders. Findings reveal that eating problems in women of color are linked to various oppressions and trauma, which allows for rethinking about theory suggesting that eating disorders are the result of appearance based obsessions (Thompson, 1992).

Research by Perez et al. (2002) looked at the role of acculturative stress and body dissatisfaction in predicting bulimic symptoms. A sample of White, Black and Hispanic females was administered measures assessing levels of acculturative stress, body dissatisfaction, and bulimic symptoms (Perez et al, 2002). Perez et al. (2002) used a regression analysis to predict bulimic symptoms in the sample. Findings indicate that high levels of acculturative stress in the women of color were correlated with increased body dissatisfaction and bulimic symptoms (Perez et al., 2002). This suggests that acculturative stress in women of color may increase vulnerabilities for developing bulimic symptoms.



Contradictory research questions the impact of acculturation on disordered eating behavior. Jennings, Forbes, McDermott, and Hulse (2006) assessed psychopathology and disordered eating behaviors in a sample of Asian and White women. Additionally, the study explored the impact of acculturation on psychopathology and disordered eating behaviors in Asian women. Participants were screened using the Eating Disorders Test (EAT-26), the Eating Disorders Inventory (EDI-2), and an Acculturation index (Jennings et al., 2006). Findings from the study suggest that Asian participants did not score higher on the EAT-26 than their White counterparts (Jennings et al., 2006). This finding reveals that Asian women appear to experience eating disorder symptoms at similar rates as White women. When looking at the data more specifically, Asian participants scored significantly higher than White participants in Ineffectiveness, Interpersonal Distrust, Maturity fears, and Social Insecurity subscales on the EDI-2 (Jennings et al., 2006). This suggests that, while symptoms did not appear to be different in each group, certain symptoms were heightened for Asian participants. Additionally, Asian participants who were considered less acculturated did not score significantly differently than Asian participants who were more acculturated. This finding contradicts research suggesting that acculturation impacts women of color by indicating that varying levels of acculturation does not impact eating disorders in Asian women. Thus, findings which identify additional factors contributing to the development of eating disorders in women of color illustrate the need to expand our conceptions about the etiology of eating disorders.

*Implications for treatment of eating disorders in women of color*

Findings from research conducted on women of color result in current diagnostic questions about the rate at which clinicians identify eating disorder symptoms in women of color. Are clinicians still influenced by stereotypes? How does the current diagnostic process impact the rate at which clinicians recognize eating disorder symptoms in women of color? As mentioned above, this study will explore these questions through the following question: Does a client's race impact clinicians' identification of eating disorder symptoms?

This research has implications for treatment and outreach for eating disorders. By understanding the state of race related biases in the diagnostic process, we explore the impact of and continued need for culturally sensitive social work training in improving diagnoses. Information from this research can be used to improve cultural competency training for social workers by allowing for a starting place to discuss biases in diagnoses. Furthermore, this research provides insight about the impact of constructed information about eating disorders in women of color on the diagnostic process. In this way, we can learn to present information in ways that reflect culturally sensitive treatment modalities.

## CHAPTER III

### METHODOLOGY

The following chapter describes the purpose of this mixed-methods study and the methodology used to conduct this research. The purpose of this mixed-methods study was to further explore the effect of race on clinicians' recognition of eating disorder symptomatology in Asian, African-American, and White women. This study replicated the work of Gordon et al. (2006) in an attempt to re-affirm or challenge previous research findings found by Gordon et al. (2006), which suggest that clinicians identify eating disorder symptoms in African American women less frequently than in White women. The present study expanded Gordon et al.'s (2006) work by assessing clinicians' identification of eating disorder symptoms in Asian women and by examining themes revealed in the qualitative portion of the narrative. The purpose of this change was to determine whether clinicians identify eating disorder symptoms in Asian women at differing rates than in White and African American women. The present study explored the following question: Does a client's race impact clinicians' identification of eating disorder symptoms?

In line with Gordon et al.'s (2006) research, it is hypothesized that clinicians will identify eating disorder symptoms in White women more frequently than in Asian and African American women. It is also hypothesized that clinicians will rate the severity of eating disorder symptoms the same regardless of race as evidenced by responses on the Drive for Thinness scale of the Eating Disorder Inventory 3-RF (Garner, 2005).

### *Research Method and Design*

A fixed methods design was used for this study. Anastas (1994) suggests that fixed method research is “designed to be invariant throughout the course of the study” (p. 29). The purpose of using a mixed-method, experimental design for this research was to control for differential diagnoses based on symptom presentation and to assess for race related biases. In this way, it was appropriate to use a design that would allow for controlled changes in variables, as well as a qualitative content analysis of the narrative to assess for race related biases.

The research took place over the course of ten months. The Human Subjects Review Board at Smith College's School for Social Work approved the methodology of this study prior to beginning this research (Appendix A). A snowball sampling technique (non-probability) was used to identify participants. This influenced the recruitment process as I obtained contact information for potential participants through my work in the field of social work, personal contacts, and through public databases on the Kenyon College and Boston College alumni web sites. Colleagues who work in a range of treatment settings were contacted in an effort to access clinicians who treat patients of all socio-economic backgrounds and who have varying needs.

Colleagues identified were emailed a letter (Appendix B) requesting participation in the study. In the introductory letter (Appendix B), individuals were informed about the purpose of this research, provided with information about the sample criteria, and provided with the primary researcher's contact information. Individuals were asked to forward the introductory email to interested colleagues in the field, who meet sample criteria, in an effort to increase sample size.

Colleagues responded by email regarding their interest in participating in the study. After receiving an email regarding individuals' intent to participate, participants were given information about the study, assessed for their appropriateness for the study, and informed that they would be sent by mail two copies of the informed consent form (Appendix C), a randomly selected case vignette (Appendix D), and a set of questionnaires. Participants were asked to provide their preferred mailing address in order to receive participation materials by mail. Participants were informed that the data collection process would take approximately 30 minutes and that, upon completion of this research, participants would receive a summary of findings.

Participants were sent by mail two copies of the informed consent form (Appendix C), a structured questionnaire requesting demographic information (Appendix E), a randomly distributed case vignette (Appendix D), which described the eating habits and school related activities of Mary, a 16 year old female whose race was identified as either African American, Asian, or White, and the Eating Disorder Inventory-RF, which included the Drive for Thinness subscale (Garner, 2004). Upon receipt of the mailing, participants signed the informed consent form, assessed the randomly distributed case vignette, completed the demographic information, and filled out the Eating Disorder Inventory-RF (Garner, 2004). Following completion of reading the case vignette, participants were asked to respond in writing to the open-ended question, "Do you think Mary has any problems, and if so, what are they?" (Gordon et al., 2006). Participants completed the Eating Disorder Inventory-RF (Garner, 2005) from Mary's perspective in an attempt to determine how clinicians rated symptomatology across ethnic groups (Gordon et al., 2006). Like Gordon et al. (2006), this study focused on the Drive for

Thinness subscale because the subscale reflects the symptoms exhibited most frequently by Mary in the case vignette. After filling out the requested information, participants returned by mail a copy of the signed informed consent form, the completed assessment, demographic information, and the Eating Disorder Inventory-RF in a pre-addressed, stamped envelope provided by this researcher.

### *Sample*

Clinicians with a Bachelor's, Master's, or Doctoral degrees in Social Work were included in the sample in order to include participants who had been trained in the field of Social Work. Additionally, participants were required to have at least one year of direct service with clients. Direct service was defined by individual, family, group, or couples counseling or case management experience. Clinicians of all genders were included in this study. Participants were required to be 22 years old or older because participants needed to have experience with diagnoses. Because of the limited scope and resources for this research, participants were required to read and write in English. The primary locations of participants were not limited by region; however, the majority of the participants' resided outside of the DC Metro Area (including Maryland, Virginia, and District of Columbia). Many of the participants resided in Massachusetts due to the location of Smith College School for Social Work.

The original sample included 39 participants. One challenge faced in obtaining participants and collecting findings was the methods used to collect data. Because study participation required that participants send back data by mail once completing the questionnaires, materials were not returned by all participants who initially expressed interest in the study. Over the course of the data collection process, one individual

dropped out of the study and four individuals did not return their completed questionnaires. Thus, the final sample included 34 participants.

### *Type of Data*

A structured questionnaire was used to collect demographic information. Participants were asked information including age, ethnicity, gender, professional degree, state of residence, and professional specialty. The case vignette used in this study was also used by Gordon et al. (2006) and Gordon et al. (2002). Permission to replicate the Gordon et al. (2006) study, which included the complete tool of Mary in the appendices, was granted by Thomas Joiner, Jr. on October 15, 2008 (Appendix F). In the present study, the Eating Disorder Inventory-3 RF, which includes the revised Drive for Thinness subscale, was used to assess clinicians' thoughts about the severity of Mary's eating disorders symptoms. Permission to use this tool was granted by PAR, Inc. (Appendix G). The Eating Disorder Inventory 3 RF is an abbreviated section of the updated Eating Disorders Inventory 3, a standardized scale used to assess eating disorder symptoms and other psychological traits (Garner, 2004). The risk composite scales of the EDI-3, which include the Drive for Thinness subscale used in this study, were found to have reliability ranges (.90-.97) (Garner, 2004). The data gathered by this tool may be compared to data collected in the Eating Disorder Inventory 2 (Garner, 2004), which was used by the Gordon et al. (2006) study, as the Drive for Thinness subscale in the EDI-3 RF (Garner, 2005) is highly correlated (.96) with the Drive for Thinness subscale of the EDI-2 (Garner, 2004).

Data was coded by this researcher and processed with the support of Marjorie Postal, Smith College School of Social Work. Data was coded and organized using Excel.

### *Ethics and Safeguards*

Because the purpose of this study is to elicit unbiased answers about clinicians' diagnoses of eating disorders in women of color and to negate preconceptions about what is being studied, participants were informed that they were participating in a study looking at the process of assessment by clinicians of women seeking help. Participants were not informed of the direct purpose of the study in order to minimize participant bias.

Two copies of the informed consent form (Appendix C) were sent to participants, so that one copy of the informed consent could be kept by participants for their records. Participants were informed that questionnaires would remain confidential and that their participation acknowledges that they have agreed to the information provided in the informed consent. Additionally, participants were informed in the informed consent form of their ability to drop out of the study by March 15, 2009. All materials pertaining to their participation in the study were immediately destroyed. Participants were informed that research advisors would have access to the data after informed consent forms had been separated from questionnaires. Data was presented as information about a group and illustrative vignettes and quoted comments were disguised. Upon receipt of the completed questionnaires, this researcher confirmed that the informed consent form was signed and complete before including the data provided in the attached questionnaire. If the informed consent form was not signed and complete, the participant was contacted



about the incomplete form and a copy of the signed informed consent was requested before data was included in the study.

In order to safeguard identifying information, each participant was assigned a number, which was marked on the questionnaires sent to each participant. Questionnaires were matched to participants' informed consent form based on this assigned number, so that, should a participant withdraw from the study, all materials pertaining to his or her participation could be destroyed. Upon this researcher's receipt of participants' questionnaires and signed informed consent forms, the informed consent forms were kept separate from questionnaires. All data will be kept in a secure location for a period of three years, as required by Federal Guidelines. Data stored electronically will also be protected through the use of a password and encryption. Materials needed after a three year period will be maintained in a secure location and will be destroyed when no longer needed.

### *Data Analysis*

A hypothesis of difference was examined using inferential statistics. An analysis of variance was used to examine the hypothesis: a client's race does not impact how clinicians rate the severity of Mary's symptoms. A single one way analysis of variance (ANOVA) was conducted on the EDI-3 RF Drive for Thinness subscale scores, while using Mary's race as an independent variable.

Like the analyses conducted in Gordon et al. (2006), chi-square analyses were used to analyze the responses to the open-ended question, "Do you think Mary has any problems and, if so, what are they?" (Gordon et al., 2006). The chi-square analyses supported the examination of the hypothesis: a client's race does impact clinicians'

identification of eating disorder symptoms. In an effort to replicate Gordon et al.'s (2006) methodology, participants' responses to the open-ended question were coded into a dichotomous variable. Because all clinicians identified a problem for Mary in the present study, the coding of the narrative was expanded from Gordon et al.'s (2006) work (variable labels "yes" and "no") to define whether or not an eating disorder was specified. The present study labeled the dichotomous variable: yes, eating disorder identified and yes, eating problems identified, but a disorder was not specified. Disturbed eating patterns not connected to an eating disorder where those defined by clinicians as "problematic," "concerning," or "nutrition" related without a specific link to an eating disorder. Disturbed eating patterns linked directly to an eating disorder were described by clinicians as behaviors of "an eating disorder."

## CHAPTER IV

### FINDINGS

The present mixed-methods study replicated Gordon et al.'s (2006) research in an effort to examine the current impact of race on clinicians' detection of eating disorder symptomatology. The first hypothesis set forth in the previous chapter suggested that clinicians are less likely to identify eating disorder symptoms in Asian and African American women. Unlike Gordon et al. (2006), who found that race significantly impacts clinicians' identification of eating disorder symptoms, quantitative findings from the present study fail to reject the first hypothesis, ultimately suggesting that race does not significantly impact clinicians' identification of eating disorder symptomatology. While the quantitative data in the present study suggests that race did not significantly impact the identification of eating disorder symptoms, qualitative data assessment found that race impacts the language used to describe eating disorder symptomatology. Because language is a key component in the diagnostic process, the differences in diagnostic language based on race may contribute to misdiagnosis of eating disorders in women of color.

The second hypothesis set forth in the previous chapter suggested that clinicians rate the severity of eating disorder symptoms the same regardless of race as evidenced by responses on the Drive for Thinness scale of the Eating Disorder Inventory 3-RF (Garner, 2005). Similar to Gordon et al. (2006), who found that race does not impact the severity

which clinicians rate eating disorder symptomatology, quantitative findings from the present study fail to reject the second hypothesis.

One hundred twenty-four individuals were initially contacted via email regarding their interest in participating in this research. A snowball sampling technique was used to obtain participants; thus, the originally contacted individuals spoke by email or directly with other colleagues about the study. Of the more the 124 individuals informed about this study, 39 participants responded regarding their interest in the study and were sent materials by mail. Of the 39 participants sent materials to participate, 34 (n=34) participants returned completed materials. The following section describes the demographic information, quantitative findings from case vignette and the Eating Disorder Inventory 3-RF, and qualitative findings.

*Demographics of Participants*

*Age*

Participants ranged in age from 26-61 years of age (mean=42.82). The most frequently occurring age of participants identified was 26 years old. The data is documented in Table 1 below.

Table 1: Age of Participants

<i>N</i>	<i>Valid Missing</i>	<i>34 0</i>
<b>Mean</b>		<b>42.82</b>
<b>Median</b>		<b>43.00</b>
<b>Mode</b>		<b>26</b>
<b>Std. Deviation</b>		<b>12.283</b>
<b>Variance</b>		<b>150.877</b>
<b>Minimum</b>		<b>26</b>
<b>Maximum</b>		<b>61</b>

### *Gender*

Participants were asked to identify their gender: female, male, and other. The majority of participants identified their gender as female. Female participants (n=29) made up 85.3% of the sample. Male participants (n=5) made up 14.7% of the sample. No individuals identified their gender as other. The data is documented in Table 2.

Table 2: Gender of Participants

<b>Valid</b>	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
<i>Male</i>	5	14.7	14.7	<b>14.7</b>
<i>Female</i>	29	85.3	85.3	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

### *Race and Ethnicity*

Race and Ethnicity was defined by the United States Census bureau. The majority of participants (n=29) identified as Non-Hispanic/White. This represented 85.3% of the sample. Participants who identified as Black or African American made up the second most frequently occurring group (n=2) representing 5.9% of the total sample surveyed. Participants who identified as Asian/Asian American (n=1), Hispanic/Latino (n=1), and other (n=1) made up of 2.9% of the total group surveyed respectively. The data is documented in Table 3.

Table 3: Race and Ethnicity

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>Asian/Asian American</b>	1	2.9	2.9	<b>2.9</b>
<b>Black/African American</b>	2	5.9	5.9	<b>8.8</b>
<b>Hispanic or Latino</b>	1	2.9	2.9	<b>11.8</b>
<b>Non Hispanic/White</b>	29	85.3	85.3	<b>97.1</b>
<b>Other</b>	1	2.9	2.9	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

*Academic Experience and Licensure*

Participants were asked to identify their highest degree completed in Social Work (Bachelor's, Master's, Doctorate) and if they held a license in the field of Social Work. The majority of participants (n=30) identified that they held a Master's degree in Social Work and that they were licensed in the field (n=29). Participants who held a Master's degree in Social Work (n=30) represented 97.1% of the sample. Participants who held a license in the field of Social Work (n=29) represented 87.9 % of the sample. Of the 34 participants surveyed, one participant identified his or her highest degree completed as a Doctoral Degree in Social Work (2.9% of the sample). While an attempt was made to obtain participants with Bachelor's, Master's, or Doctoral degrees in Social Work, no participants identified a Bachelor's degree as their highest degree completed in the field. Of the 33 participants who provided information about licensure, four participants identified themselves as not licensed representing 12.1% of the sample. The data is reflected in Table 4 and 5.

Table 4: Highest Degree Completed

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>Masters</b>	33	97.1	97.1	<b>97.1</b>
<b>Doctorate</b>	1	2.9	2.9	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

Table 5: Licensed Social Worker

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>Yes</b>	29	85.3	87.9	<b>87.9</b>
<b>No</b>	4	11.8	12.1	<b>100.0</b>
<b>Total</b>	33	97.1	100.0	
<b>Missing</b>	1	2.9		
<b>Total</b>	<b>34</b>	<b>100.0</b>		

*State of Residence*

Participants identified their state of residence as DC, Maryland, Virginia, or Other. Participants who identified their state of residence as other were asked to identify their state of residence. The majority of participants (n=23) surveyed resided outside of DC, Maryland, and Virginia (identifying their state of residence as other) representing 67.6% of the sample. Of the states identified as other, the majority of participants (n=13) resided in Massachusetts representing 38.2 % of the sample. Participants residing in Maryland (n=5) represented the second most frequently occurring state of residence representing 14.7% of the sample. Participants residing in Virginia (n=4) represented the third most common state of residence representing 11.8% of the sample. Participants also resided in the District of Columbia (n=2), California (n=2) and Illinois (n=2) each representing 5.9% of the sample respectively. Additionally, participants resided in the

following states: Connecticut, Maine, Minnesota, New Jersey, New York, North Carolina. The data is outlined in Table 6 and 7.

Table 6: State of Residence

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>District of Columbia</b>	2	5.9	5.9	<b>5.9</b>
<b>Maryland</b>	5	14.7	14.7	<b>20.6</b>
<b>Virginia</b>	4	11.8	11.8	<b>32.4</b>
<b>Other</b>	23	67.6	67.6	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

Table 7: State of Residence-Other

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>DC, Virginia, Maryland</b>	11	32.4	32.4	<b>32.4</b>
<b>California</b>	2	5.9	5.9	<b>38.2</b>
<b>Connecticut</b>	1	2.9	2.9	<b>41.2</b>
<b>Illinois</b>	2	5.9	5.9	<b>47.1</b>
<b>Maine</b>	1	2.9	2.9	<b>50.0</b>
<b>Massachusetts</b>	13	38.2	38.2	<b>88.2</b>
<b>Minnesota</b>	1	2.9	2.9	<b>91.2</b>
<b>New Jersey</b>	1	2.9	2.9	<b>94.1</b>
<b>New York</b>	1	2.9	2.9	<b>97.1</b>
<b>North Carolina</b>	1	2.9	2.9	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

### *Quantitative Findings*

#### *Case Vignette: Story of Mary*

Participants read the case vignette of Mary, a 16 year old Asian, African American, or White female. Two groups of eleven participants (n=11) were randomly selected to read the case vignette for Mary when she was Asian or African American.



Both groups made up 32.4% of the sample respectively. Twelve participants (n=12) were randomly selected to read the case vignette for Mary when she was White comprising 35.3% of the sample.

The data is listed in Table 8 below.

Table 8: Race of Mary

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>African American</b>	11	32.4	32.4	<b>32.4</b>
<b>White</b>	12	35.3	35.3	<b>67.6</b>
<b>Asian</b>	11	32.4	32.4	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

Chi-square analyses were run on the open-ended responses provided by clinicians at the end of the case vignette with Mary's race as the independent variable. Participants' responses to the question, "do you think Mary has any problems and if so, what are they?" were coded into a dichotomous variable: yes, eating disorder identified and yes, eating problems identified, but a disorder was not specified. Data collected from the chi-square analyses can be found in Appendix H. Chi-square analyses were used to assess if Mary's race impacted the likelihood of clinicians' identification of eating disorder symptoms. Findings from the chi-square analyses indicate that race does not significantly impact the likelihood of clinicians' identification of eating disorder symptomatology.

Of the 34 (n=34) total participants, 47.1% of participants (n=16) identified eating disorder symptomatology in the case vignette and linked Mary's symptoms to an eating disorder. 52.9% of the total participants (n=18) identified eating/nutrition problems in

Mary, but did not link these symptoms to a specific disorder. The data is illustrated in Table 9.

Table 9: Eating Disorder Pattern

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>Yes, Eating Disorder Symptoms Identified</b>	16	47.1	47.1	<b>47.1</b>
<b>Yes, Eating/Nutrition Problems identified, no disorder specified</b>	18	52.9	52.9	<b>100.0</b>
<b>Total</b>	<b>34</b>	<b>100.0</b>	<b>100.0</b>	

Participants most frequently identified eating disorder symptomatology in the case vignettes when Mary was white (n=8) representing 66.7% of the total sample in this group (n=12). Five clinicians (n=5) identified eating disorder symptomatology in Mary when she was African American representing 45.5% of the total case vignettes in this group (n=11). Clinicians identified eating disorder symptomatology less frequently in the case vignettes when Mary was Asian (n=3) representing 27.3% of the total case vignettes in this group (n=11).

Clinicians identified eating/nutrition problems in Mary, but did not link these problems to a disorder most frequently in the case vignettes when Mary was Asian (n=8). This represented 72.7% of the total case vignettes in this group (n=11). Eating/nutrition problems were noted in 54.5% of the case vignettes when Mary was African American (n=6). Clinicians identified eating/nutrition problems least often in the case vignettes

when Mary was white (n=4) representing 33.3% of the total case vignettes in this group (n=12). This data is reflected in Table 10 below.

Table 10: Eating Disorder Patterns Identified by Race

<i><b>Eating Disorder Pattern Identified</b></i>	<i><b>Mary's Race: African-American</b></i>	<i><b>Mary's Race: White</b></i>	<i><b>Mary's Race: Asian</b></i>	<i><b>Total</b></i>
<b>Yes, eating disorder symptoms identified</b>	5 45.5 % (percent within Mary's race)	8 66.7% (percent within Mary's race)	3 27.3% (percent within Mary's race)	<b>16</b> <b>47.1%</b>
<b>Yes, eating/nutrition problems identified, disorder not specified</b>	6 54.5% (percent within Mary's race)	4 33.3% (percent within Mary's race)	8 72.7% (percent within Mary's race)	<b>18</b> <b>52.9%</b>
<b>Total</b>	<b>11</b> <b>100.0%</b>	<b>12</b> <b>100.0%</b>	<b>11</b> <b>100.0%</b>	<b>34</b> <b>100.0%</b>

*Eating Disorder Inventory 3- Referral Guide*

Data collected from the Drive for Thinness subscale of the Eating Disorder Inventory 3-RF (EDI-3RF) can be found in the table in Appendix I. The EDI-3RF assesses beliefs about dieting, body weight, and problematic eating patterns (Garner, 2004). Participants filled out the EDI-3RF, which includes the Drive for Thinness subscale, from the perspective of Mary in an effort to further assess clinicians' beliefs about Mary's eating behavior. The Drive for Thinness subscale assesses "an extreme desire to be thinner, concern with dieting, preoccupation with weight, and intense fear of weight gain" (Garner, 2004, p.16). The Drive for Thinness subscale of the EDI-3 RF was used in this study because it most reflects the characteristics displayed by Mary in the narrative.

A one-way ANOVA was run using Drive for Thinness overall scores and Mary's race in the case vignette. Data collected from this analysis can be found in Appendix J. The ANOVA was used to assess the differences among the three groups (Asian, African American, and White) on the rated severity of Mary's eating disorder symptoms on the Drive for Thinness subscale of the EDI-3RF. Findings indicate that Mary's race did not significantly impact clinicians' rating of Mary's eating disorder symptoms. Clinicians rated the severity of Mary's eating disorder symptoms moderately high (overall mean=17.63, SD=7.03). A typical mean score of adolescent girls on the Drive for Thinness subscale is approximately 21 (Gordon et al., 2006).

#### *Qualitative Findings*

A content analysis was performed on the responses to the following open-ended question: "Do you think Mary has problems and, if so, what are they?" The responses were thematically coded and quantified to measure the following theme: racial stereotypes in language. Stereotypes are "a set of beliefs and cognitions about the characteristics of members of a social group" (Bobo, 2001 as cited by Miller and Garran, 2008, p. 95). While no statistically significant differences were found by race based on clinicians' identification of eating disorder symptomatology, content analysis of the narrative reveals that the language used by clinicians to describe the symptoms of Mary reflects racial stereotypes. The stereotypes assessed by race in this analysis related to beliefs about family involvement, perfectionism, and additional reasons for restricted eating patterns.

### *Stereotypes present in the diagnostic process*

Miller and Garran (2008) suggest that "stereotypes do not evolve in a vacuum. They reflect and contribute to public discourses about groups, encoding attitudes, guiding behaviors, while staking out social boundaries" (p. 95). Findings in the narrative reveal that racial stereotypes are present in the diagnostic language used by clinicians when describing the symptoms of Mary in the case vignette. Despite presenting clinicians with the same symptom profile for Mary across racial groups, the diagnostic language used by clinicians to describe Mary's symptoms and to describe follow up questions to increase understanding about Mary's symptoms varied by race.

Of the 11 case vignettes when Mary was African American, five clinicians identified the family in their description of Mary's problems. In general, when the family was discussed in the narrative when Mary was African American, clinicians mentioned family absence or limited family support as a problem. One clinician described the absence in the family by stating that there is "limited family contact/support." A second clinician questioned family involvement at mealtimes by stating, "where is her family? It does not sound as if they eat many meals together or do anything together." A third clinician also reflected upon family mealtimes, "there is no mention of the family. Do they eat together?" Lastly, a fourth clinician questioned the cultural beliefs around food by stating "what is the family's culture and beliefs about food?"

Despite having the same symptom profile when Mary was White, the family was mentioned in only 3 of the 12 case profiles. Of the three case profiles that mentioned family, one clinician discussed the family in the context of gathering more information to assess Mary. The clinician stated, "I would gather more information from the

parents/caregivers about eating patterns in the home." While questions about family involvement emerged when Mary was White, the phrasing of the discussion about family in one of the cases appeared to be related to the use of family as a means for additional clarification about Mary's behavior. Thus, while the responses of all five clinicians who read the case vignette for Mary (African American) discussed family in the context of absence, one of the three responses by clinicians in the case vignette for Mary (White) mentioned family as a means to gather additional information.

Despite reading the same symptom profile as those who read the case vignettes for Mary when she was White or African American, 1 of the 11 clinicians who read the case vignette of Mary when she was Asian suggested that family communication was a problem. When the family was mentioned in this vignette, the discussion focused on family communication instead of family absence or family as a means for additional clarification about Mary's behavior. One clinician states, "Family communication seems to be a problem because she eats at home and her parents do not even seem to know that she is restricting."

Of the 11 case vignettes when Mary was identified as Asian, five clinicians identified a drive for perfectionism as a problem for Mary. Perfectionism was identified most often in case vignettes when Mary was Asian. One clinician stated, "perfectionism-what strands control most heavily: familial, financial, self, academic, social context." Another clinician stated that he or she would "ask about her experience of academic performance." Lastly, a clinician noted, "Mary appears to be hard/critical of herself as well as highly demanding of herself. She is not forgiving of her mistakes or troubles in school (as judged against her own standards)."

Of the 11 case vignettes when Mary identified as African American, three clinicians identified perfectionism as a symptom of Mary in the vignette. One clinician stated, "Mary appears to eat less when under stress or upset by performances on a test (perfectionism?) and might be "punishing" herself by restricting food." Another clinician stated, Mary is an "overachiever with a need for perfection." Lastly, a clinician stated that Mary displays "perfectionist attitudes."

Of the 12 case vignettes when Mary identified as White, two clinicians identified high achievement as a problem for Mary. One clinician stated, "high achiever/constantly preoccupied with success." Another clinician stated, "Being a white female places her at risk for feelings of overachievement and unrealistic expectations of success."

Interestingly, in the responses to the case vignettes when Mary was White, the language of "overachievement" and "unrealistic expectations of success" were used instead of the language of "perfectionism."

Of the 34 responses, one response to a case vignette when Mary was African American stated that "restricted eating may also be due to lack of appetite, which could be caused by hyperthyroid, physical illness, depression, medication side effects, poverty." This was a notable finding because "poverty" was not mentioned as a reason for Mary's restricted eating in the case vignettes when Mary was Asian or White.

## CHAPTER V

### DISCUSSION

The following chapter will evaluate findings from the present mixed-methods study, which explored the impact of race on clinicians' recognition of eating disorder symptomatology. The following chapter discusses study findings in the context of current literature, while examining data from the qualitative portion of this study to further describe the impact of race on the diagnostic process. This chapter also discusses quantitative data findings as they compare to the findings from the Gordon et al. (2006) study. Additionally, this discussion addresses the strengths and limitations of the present study, discusses implications for social work practice, and proposes recommendations for future research.

#### *Current Findings and Previous Literature*

##### *Quantitative Findings*

The present mixed-methods study replicated the work of Gordon et al.'s (2006) in an attempt to re-affirm or challenge Gordon et al.'s (2006) findings, which suggest that clinicians identify eating disorder symptoms in African American women less frequently than in White women. Furthermore, the present study expanded Gordon et al.'s (2006) work by assessing clinicians rate of symptom recognition in Asian women and by further discussing themes present in the qualitative data collected in the narrative. Interestingly, quantitative findings from the present study challenge Gordon et al.'s (2006) work by suggesting that race does not significantly impact clinicians' rate of identification of



eating disorder symptomatology. These findings do not support previous research which suggests that a client's race influences the mis-diagnoses of persons of color (Blow et al., 2004; Gordon et al., 2006; Gordon et al., 2002). The reasons for this finding are explored below.

Quantitative findings from the present study, which challenge those from the Gordon et al.'s (2006) study, may be the result of differences in sample demographics including participants' training and level of education, the time lapse since the previous study, differences in the coding of the narrative, and the exploration of symptom recognition by clinicians in Asian women. In the Gordon et al. (2006) study, 22 clinical psychology graduate students and 69 clinicians with mental health degrees (n=91) participated in the study (p. 320). Unlike the sample in the Gordon et al. (2006) study, the sample in the present study consisted of 34 participants (n=34). The difference in sample size may have led to differences in findings, as a larger sample may be more representative of clinicians at large.

The similarity in training background of clinicians in the present study may have led to findings that challenge the work of Gordon et al. (2006). While participants in the Gordon et al. (2006) study received varying training in the mental health field, all participants in the present study were trained in the field of Social Work. It is possible that the social work training received by participants in the present study prepared the clinicians to examine clients within their cultural context, contributing to the identification of eating disorder symptomatology in various ethnic groups.

The similar education level of clinicians in the present sample may also have led to findings that challenge the work of Gordon et al. (2006). While the majority of

participants in the Gordon et al. (2006) study held advanced degrees in the mental health field (37.1% of the sample held Master's degrees and 39.3% of the sample held doctoral degrees in various mental health professions) (Gordon et al., 2006, p. 320), all clinicians in the present study held advanced in the field of Social Work (97.1% held Master's, 2.9% held Doctoral degrees). Master's and Doctoral level degrees in Social Work may support clinicians' understanding of race related biases in the diagnostic process leading to differences in findings between the two studies.

The three-year time lapse since the Gordon et al. (2006) study may have contributed to differences in findings in the present study. Research about eating disorders has expanded regarding the needs of clients in various ethnic groups; thus, leading to more information and training for clinicians about the needs of clients of color. In this way, clinicians may have more information about eating disorders in women of color and may be better able to identify symptoms patterns in various ethnic groups.

Differences in variable coding of the narrative in the present study may also have led to findings that challenge those in the Gordon et al. (2006) study. In the Gordon et al. (2006) study, the narrative was coded into a dichotomous variable: "yes" (Mary has problems) or "no" (Mary does not have any problems). Unlike the Gordon et al. (2006) study, where some participants did not identify eating disorder symptoms in Mary, all clinicians in the present study identified problems with Mary. Thus, the narrative in the present study was coded into a dichotomous variable: "yes, eating disorder identified" and "yes, eating/nutrition problems identified, but not linked to a disorder." The purpose of this change in study methodology was to describe patterns of symptom recognition in a way that reflected that all clinicians in the present study identified a problem in Mary.

Lastly, the present study explored clinicians' identification of eating disorder symptomatology in Asian, African American, and White women. This differed from the Gordon et al. (2006) study, which looked at clinicians' identification of eating disorder symptoms in Hispanic, African American, and White women. This difference may also have led to findings that challenge those in the Gordon et al. (2006) study and findings from previous research that suggests that race influences diagnoses. Additionally, the present study looked at the identification of symptomatology and not the final diagnoses of women of color.

Quantitative findings from analyses of data from the EDI-3RF (Garner, 2005) suggest that race does not significantly impact clinicians' severity ratings of eating disorder symptoms. These findings support the hypothesis set forth in chapter three and support the findings in the Gordon et al. (2006) study, which suggest that there is no significant difference in the way that clinicians rate the severity of eating disorder symptoms across ethnic groups. Quantitative findings from the present study suggest that clinicians are able to identify the severity of Mary's eating disorder symptoms even if the identified symptoms are not specifically linked to an eating disorder in the language of the narrative. This is an interesting finding because it suggests that race may influence clinicians' comfort level in linking eating disorder symptoms to a specific diagnosis.

This finding may explain why previous research found that race influenced diagnoses, as clinicians' comfort level with making diagnoses may vary when working with clients from various ethnic groups and may ultimately impact final diagnoses of persons of color. Interestingly, eating disorder symptoms were linked to an eating disorder least often when Mary identified as Asian (27.3% of the total case vignettes in

this group (n=11)) as compared to when she identified as African American (45.5% of the total sample in this group (n=11) or White (66.7% of the total sample in this group (n=12)). This is a notable finding because, despite clinicians' moderately high symptoms rating on the EDI-3RF across racial groups (M=17.63, a typical mean score of adolescent girls on the Drive for Thinness subscale is approximately 21 (Gordon et al., 2006)), clinicians were more comfortable linking eating disorder symptoms to an eating disorder when Mary identified as White than when Mary identified as Asian. Because Mary's symptom pattern in the narrative was the same across racial groups, the difference in diagnoses appears to be related to the change in Mary's race and not due to different symptom presentations. This suggests that clinicians may have different expectations about the likelihood of Asian clients experiencing eating disorders than White clients or may be less comfortable diagnosing Asian clients with eating disorders.

Haynie (2009) suggests that clinicians may attribute an Asian client's thinness to genetics rather than to eating disorders due to racial stereotyping that suggests that Asian women have thin physiques. Clinicians in the present study seemed reluctant to make specific eating disorder diagnoses in Mary when she identified as Asian. This could be the result of additional questions about the cause of Mary's thin physique. Furthermore, this finding suggests that Asian women may be less likely than White women to receive an early diagnosis of an eating disorder, as diagnoses are made by linking symptoms to a direct diagnosis. This finding is in line with Root's (1990) statement which suggests that women of color often suffer from an eating disorder for an extended period of time before accurate assessment is made.

### *Qualitative Findings*

Poland and Caplan (2004) suggest that clinicians may exhibit bias by valuing certain information over other information and/or by judging a client from an ethnic group as suffering from a mental illness more or less readily than a client from a different ethnic group (Poland & Caplan, 2004). While quantitative findings suggest that race does not significantly impact clinicians' rate of identification of eating disorder symptomatology, qualitative findings from the content analysis of the narrative reveal that stereotypes are evident in the diagnostic language used by clinicians. This is a significant finding because language has a profound impact on the diagnostic process.

Stereotypes present in diagnostic language, which was found in the narrative portion of the present study, may contribute to later mis-diagnoses of persons of color. Findings in the present study suggest that the language used by clinicians to describe symptoms in persons of color reflects racial stereotypes and displays bias by placing value on certain information over other information. This fascinating finding from the present study further explains why previous research found that persons of color are often over-diagnosed or under-diagnosed with mental illness (Loring & Powell, 1988, as cited by Whaley, 2004, p. 78; Gordon et al., 2002). In this way, language in the present study that does not link eating disorder symptoms directly to an eating disorder or that reflects racial stereotyping appears to impact clinicians' understanding of the symptom pattern presented in the case of Mary, which may contribute to the later mis-diagnoses of persons of color.

While eating disorder symptomatology was identified by clinicians regardless of Mary's race, qualitative findings suggest that the language used to describe eating disorder

symptoms appeared to vary by race and to reflect racial stereotypes. This is particularly evident in analysis based on discussions about family involvement and Mary's perceived perfectionism. In general, when the family was discussed in the narrative when Mary was African American, clinicians mentioned family absence or limited family support as a problem. This is reflective of racial stereotypes that suggest that family absence is common in the African American community. For example, one clinician questioned family involvement at mealtimes by stating, "where is her family? It does not sound as if they eat many meals together or do anything together." This is a notable finding because the family was mentioned in only 3 of the 12 cases when Mary was White and in 1 of the 11 cases when Mary was Asian. This suggests that racial stereotypes about family presence in the lives of African American women influenced the language used by clinicians to describe Mary's symptoms and influenced the symptoms that were discussed or discounted within the narrative. Findings from the present study mirror those found in the Gordon et al. (2002) study, which suggest that participants discounted specific symptom information when Mary identified as Hispanic or African American, but discussed these symptoms when she identified as White.

Clinicians identified symptoms of perfectionism most frequently in Asian women (5 of the 12 cases). This is reflective of racial stereotypes based on the stereotypical idea of the "model minority," which suggest that Asian women are high achievers. This is a notable finding because perfectionism/over-achievement was mentioned in 2 of the 12 cases when Mary was White and 3 of the 11 cases when Mary was African American. Interestingly, the language used by clinicians to describe high achievement in Mary when she identified as Asian and African American was "perfectionism" and when she

identified as White was "over-achievement." While this reflects differences in the clinical language among the participants surveyed, it also appears to reflect how clinicians' schemas, constructed through experience and belief systems, influence the ways in which symptoms are described by clinicians.

Of the 34 narratives assessed in the present study, one response to the case vignette when Mary was African American stated that "restricted eating may also be due to lack of appetite, which could be caused by hyperthyroid, physical illness, depression, medication side effects, poverty." This was a notable finding because "poverty" was not mentioned as a reason for Mary's restricted eating in the case vignettes when Mary was Asian or White. This fascinating finding suggests that beliefs about racial groups influence clinicians' interpretation of symptoms.

Just as clinicians interpret symptoms based on their belief systems, research based on early research conducted on White women influences the way findings are interpreted and theories are constructed. Research conducted from this framework suggests that African American women are "protected" from eating disorders based on findings that conclude that African American women have "better self-images, high self-esteem, greater emotional stability, and less self-consciousness than their White peers" (all variables thought to influence eating disorders in White women) (Rosenburg, 1975 as cited by Root, 1990, p. 527; Striegel-Moore & Smolak, 2000). Findings from the present study support this model by revealing that frameworks, developed out of belief systems about various ethnic groups, influence the interpretation of symptoms and the diagnostic process.

The language used to assess clients has significant impact on diagnoses, as the perceived reason for the symptoms (poverty vs. restricting) may influence a clinician's diagnosis of an eating disorder. Findings from the present study indicate that clinicians' beliefs about Mary's motivation for not eating varied by race. For example, clinicians often attributed Mary's (Asian and African American) eating behavior to "problems with nutrition" or, as described in the case above, resulting from "a lack of appetite, which could be caused by hyperthyroid, physical illness, depression, medication side effects, poverty." This differed from descriptions of Mary's eating behavior when she identified as White, which suggested the Mary's lack of eating was due to "restricting eating." This has significant implications for eating disorder diagnoses, as problems with nutrition based on the role of poverty or under eating without restricting does not indicate a diagnosable eating disorder.

#### *Strengths and Limitations of the Study*

Replicating the work of Gordon et al.'s (2006) in the present study was a strength of the study, as it supports the validity of the findings and leaves room for future research to explore the ways in which the quantitative research questioned challenged previous findings. The homogeneity of the sample in terms of education level and training in the field of Social Work also was a strength of the present study because it allowed for an exploration of the training in diagnoses in the field of social work and leaves room for specific improvement to training within the field. Furthermore, expanding the work of Gordon et al. (2006) to look at clinicians' identification of eating disorder symptomatology in Asian women was a strength of the study because it allowed for findings reflecting new information about the diagnostic process in Asian women.



The open-ended question used in this study, “Do you think Mary has problems and, if so, what are they?” was both a strength and limitation. The open-ended nature of the question allowed for clinicians to write a narrative reflecting their thought process and allowed for qualitative data to be collected from the narrative. This allowed for an increased understanding about the role of language in the diagnostic process. Limitations to this question include the coding of findings, which differed from the Gordon et al. (2006) study. This was a limitation because the methodology of the Gordon et al. (2006) study could not be replicated in its entirety.

The case vignette used in the present study provided clinicians with limited information to assess Mary. The case of Mary was used in the present study in an effort to replicate the case narrative used by Gordon et al. (2006). Even so, the limited information provided may have contributed to hesitation about linking symptoms to an eating disorder. While the case narrative allowed for an exploration of clinicians' initial feelings when making a diagnoses, future research should explore if clinicians would make different diagnoses based on more information.

Of the total sample of 34 participants, 85.3 % identified their race/ethnicity as White. This was a limitation to the study as the sample was not representative of clinicians at large. Furthermore, future research could assess the impact of a clinicians' race on the diagnostic process. The sample was made up of 34 clinicians. The limited size of the sample influences the generalizability of the data. Furthermore, splitting the small sample into three groups may have contributed to non-statistically significant findings in the quantitative data. It may be beneficial to gather a larger sample in future research.

It is important to address that the measures used to assess eating disorders in women of color may not describe the full range of experience of an eating disorder in various ethnic groups. These measures are biased towards the presentations of eating disorders in European Americans and many not describe the experiences of women of color. Individuals diagnosed with an eating disorder will be reflective of individuals who engage in behaviors as defined above (purging, binge eating, and restriction). These presentations may limit the understanding of clinicians' diagnoses to the diagnosis of individuals who present as having eating disorders based upon the current definitions of eating disorders.

#### *Implications for Social Work Practice*

Implications for social work practice indicate a need for further assessment of clinical language used in diagnoses. Practice implications suggest that clinicians need to better assess their chosen language used in written documentation. In order to support with this process, clinicians should have further training in race related biases present in the diagnosis process. Clinical language during assessment appears to influence diagnoses and may contribute to the under diagnosis of eating disorders in women of color. It is imperative that clinical social work programs support students in examining racial stereotypes, as stereotypes appear to influence clinicians' interpretation of symptoms and the language used to describe symptomatology.

#### *Recommendations for Future Research*

Future research should continue to look at the use of language as a form of bias in the diagnostic process. Language as reflective of racial bias should be explored. It may be beneficial in future research to include eating disorder specialists to assess for

differing rates of symptom recognition. Additionally future research should explore clinicians' comfort level with making a specific diagnosis based on a symptom profile.

### *Conclusion*

While previous literature hypothesized that varying symptomatology in persons of color, stringent diagnostic criteria, and a mis-interpretation of factors contributing to eating disorders in women of color may influence mis-diagnoses of persons of color, the use of stereotypical language by clinicians in the diagnostic process provides new reasons for why persons of color may be mis-diagnosed with mental illnesses. Thus, it is imperative to focus on the usage of culturally sensitive clinical language to help support accurate diagnoses and proper treatment services for persons from various ethnic groups. Clinicians need to be trained further to explore their personal biases as they impact clinical language in an effort to improve diagnoses for all persons seeking mental health treatment.

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## APPENDIX A

### Human Subjects Review Board Approval Letter

December 28, 2008

Kristin Swenson  
4101 Albemarle Street Apt. 431  
Washington, DC 20016

Dear Kristin,

Your second set of revisions has been reviewed and all is now in order. We are happy to give final approval to this interesting study. If you do find that race has a strong impact on diagnosis, it will be quite a message to your participants when they get the summary.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Caroline Hall, Research Advisor



## APPENDIX B

### Email to Colleagues

Dear Colleague,

My name is Kristin Swenson and I am a second year graduate student at Smith College's School of Social Work. As part of my graduate studies, I am conducting a Master's thesis project that will involve the collection of data. The data will be used for a Master's thesis publication and presentation and may be used for future publications and presentations. The purpose of this study is to explore the process of assessment by clinicians of women seeking help. I am hoping to identify colleagues who would like to participate in this study. This research will provide more information about social work in an effort to improve social work training. I am looking forward to speaking further with interested colleagues who fit the criteria listed below:

- have a bachelor's, master's, or doctorate level degree in Social Work
- have a clinical background that includes at least one year of individual, family, group, couples counseling or case management work
- are able to speak and write in English
- Participants of all genders and who reside in all regions of the country may participate in this research.
- 22 years of age or older

Participants will be asked to designate approximately thirty minutes to provide demographic information, to read a short case vignette, and to complete an assessment, all of which will be sent to participants by mail. Upon completing the information, participants will be asked to send the information by mail in a pre-addressed, stamped envelope provided by this researcher

If you are interested in participating in this study, please contact me by e-mail at <XXXX@XXXX> with the best way for me to contact you further about this study. Please also feel free to contact me directly by telephone at (XXX) XXX-XXXX regarding your interest in this study or questions pertaining to this research. Thank you for your help with this process!

Best,

Kristin Swenson, M.Ed

## APPENDIX C

### Informed Consent

Dear Participant,

Thank you for your interest in this study! As part of my graduate studies at Smith College School for Social Work, I am conducting a Master's thesis project that will involve the collection of data. The purpose of this study is to explore the process of assessment by clinicians of women seeking help. The data will be used for a Master's thesis publication and presentation and may be used for future presentations and publications.

Please designate approximately thirty minutes to complete information related to this research. During this time, you will be asked to provide demographic information including age, ethnicity, gender, professional degree, professional licensure if any, state of residence, and professional specialty, to read the story of Mary, to make an assessment of Mary, and to fill out the Eating Disorder's Inventory-3 RF as you expect Mary would. All questionnaires are enclosed in this mailing. Upon completion of the questionnaires, please send by mail a copy of this form signed and the completed questionnaires in the pre-addressed, stamped envelope provided.

Because this study seeks to gather information about the social work field, participants are required to have a bachelor's, master's, or doctorate level degree in Social Work, have a clinical background that includes individual, family, group, couples counseling or case management work, and be able to speak and write in English in order to participate in this research. Additionally, participants must be 22 years or older. Participants of all genders and who reside in all regions of the country may participate in this research.

The risks of participating in this study are minimal. Your participation in this study will contribute to the field of social work in an effort to improve social work training. You will be sent a summary of findings upon completion of this research.

In order to keep the information that you provide confidential, informed consent forms will be kept separate from the questionnaires. Research advisors will have access to the data after informed consent forms have been separated from questionnaires. Data collected will be presented as information about a group and thus, individuals will not be identified. Quoted comments will be disguised.

All data will be kept in a secure location for a period of three years, as required by Federal Guidelines. Data stored electronically will also be protected through the use of a password and encryption. Materials needed after a three year period will be maintained in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary and you may drop out of the study at any time prior to March 15, 2009. You also may refuse to answer any questions without penalty. Please contact me by telephone at XXX-XXX-XXX or by email at <XXX@XXXX> if you choose to drop out of the study. All materials pertaining to your participation will be immediately destroyed.

If you have additional questions, wish to withdraw from this study during your participation, would like to receive a summary of findings upon completion of this study, or have any concerns about your rights as a participant; please feel free to contact me by telephone at XXX-XXX-XXXX or by email at <XXX@XXXX>. You also may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974 regarding questions or concerns. Please keep a copy of this informed consent form for your records. I look forward to working with you!

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of participant

## APPENDIX D

### Case Vignette

*Please read the following passage and then follow the instructions at the end of the passage.*

Mary, 16 Year old African American female (Gordon et al., 2006)

Monday: She woke up and took a shower. Mary tried on three different outfits before choosing what she was going to wear. Mary did her hair twice before leaving to school. For breakfast, she had a banana. Mary went to school. During lunch, she ate three rice cakes and had apple juice. After school, Mary had soccer practice for 2 hours and then went home. When she got home, she took a shower. She next did her homework. For dinner, Mary ate salad and a baked potato. She watched TV for 2 hours and then went to bed.

Tuesday: She woke up and took a shower. Mary tried on several different shirts before choosing which one she was going to wear. She spent half an hour curling her hair. She didn't have time for breakfast so she drank some orange juice. Mary went to school. During lunch, she ate some pretzels, soda, and a pear. After school, Mary had soccer practice for 2 hours and had an one hour meeting for Key Club. When she got home, she drank some water and took a shower. She next did her homework. For dinner, Mary ate a small bowl of vegetable soup with crackers and drank a diet soda. She studied for a test for 2 hours, picked out her clothes for the next day for half an hour, and then went to bed.

Wednesday: She woke up and took a shower and got dressed. Mary did her hair for 20 minutes. She had a piece of toast and some apple juice for breakfast. Mary had a test in the morning which she felt she did poorly on and was upset. Instead of eating lunch, she did her homework. After school, Mary had soccer practice for 2 hours and then went home. When she got home, she drank some diet soda. She then took a shower and watched TV. For dinner, Mary ate some crackers, a salad, and drank some water. Mary watched TV for 2 hours, talked on the phone for an hour and a half, and then went to bed.

Thursday: She woke up and took a shower. She took 1 hour to get dressed and did her hair for 20 minutes. For breakfast, she ate an apple. She went to school. For lunch, she had a granola bar, an orange, and some skim milk. She gave a 2 minute presentation in an afternoon class. After school, she had soccer practice for 2 hours and then went home. When she got home, she didn't eat anything and just took a shower. She talked on the phone for 2 hours and watched some TV. For dinner, Mary drank some water and had a bag of chips. She then watched TV and had some raisins before going to bed.

Friday: She woke up and took a shower. She took half an hour to get dressed and just brushed her hair. For breakfast, she had a grapefruit. She went to school and found out

she did poorly on the test she took on Wednesday and was upset. During lunch, she ate an egg salad and some grape juice. After school, Mary had soccer practice for 2 hours and then went home. She went home and took a shower. She watched TV. For dinner, she ate some black beans and rice with water. She then went to the movies with her friends.

Please answer the following question:

“Do you think that Mary has any problems and, if so, what are they?”

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APPENDIX E

Demographic Data Questionnaire

*Please answer the questions listed below.*

1. What is your age? \_\_\_\_\_
2. How do you identify your gender? (circle below)  
Male  
Female  
Other
3. Please identify the race/ethnicity that best defines you (check the appropriate line below)  
American Indian or Alaska Native \_\_\_\_\_  
Hawaiian or Other Pacific Islander \_\_\_\_\_  
Asian or Asian American \_\_\_\_\_  
Black or African American \_\_\_\_\_  
Hispanic or Latino \_\_\_\_\_  
Non-Hispanic White \_\_\_\_\_  
Other \_\_\_\_\_
4. What is your highest degree completed? (circle below)  
Bachelor's degree  
Master's degree  
Doctoral degree
5. What is your professional specialty, if any? \_\_\_\_\_
6. Are you a licensed social worker? (circle below)  
Yes If yes, please list level of social work licensure \_\_\_\_\_  
No
7. What is your state of residence? (circle below and list if appropriate)  
District of Columbia (DC) Other \_\_\_\_\_  
Maryland  
Virginia

## APPENDIX F

### Permission to replicate study

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**Kristin Swenson <XXXX@XXXX.com>**

**Wed, Oct 15, 2008 at 1:24 PM**

To: [joiner@psy.fsu.edu](mailto:joiner@psy.fsu.edu)

To Whom It May Concern:

My name is Kristin Swenson and I am a graduate student at Smith College's school for social work. As part of our graduate program, we are conducting research to be used for a Master's thesis. I am interested in conducting research on the impact of race on clinician's diagnosis of eating disorders. Thus, I am writing to request permission to replicate the 2006 study conducted by Kathryn Gordon, Marissa Brattole, LaRicka Wingate, and Thomas Joiner Jr. entitled The Impact of Client Race on Clinician Detection of Eating Disorders. I would be happy to answer any additional questions as necessary. I would appreciate your confirming receipt of this email. Thank you!

Best,

Kristin Swenson

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**Thomas Joiner**

**Wed, Oct 15, 2008 at 2:43 PM**

Reply-To: [joiner@psy.fsu.edu](mailto:joiner@psy.fsu.edu)

To: Kristin Swenson <XXXXX @XXXX.com>

sure thing.

[Quoted text hidden]

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Thomas Joiner, Ph.D.  
Distinguished Research Professor &  
The Bright-Burton Professor of Psychology  
Editor, Journal of Social & Clinical Psychology  
Florida State University  
Tallahassee, FL 32306-1270

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**Kristin Swenson <XXXXX@XXXX.com>**

**Wed, Oct 15, 2008 at 3:21 PM**

To: [joiner@psy.fsu.edu](mailto:joiner@psy.fsu.edu)

Thank you so much! I appreciate your getting back to me so quickly.

Best,  
Kristin

## APPENDIX G

### Permission to use EDI-3RF

Dear Ms. Swenson,

We are happy to consider granting you permission to administer the Drive for Thinness scale of the EDI-3 online, however, we have a minimum license fee of \$250.00 to administer our tests online.

The royalty/license fee for 60 administrations of the 7 items in the DT Scale of the EDI-3 is \$16.80 (\$0.28 per administration for 60 administrations), but you would be required to pay the \$250.00 minimum fee. Total fee due would be \$250.00.

Please let me know how you would like to proceed. I look forward to hearing back from you.

Regards,

*Vicki Mark*

Permissions Specialist

Psychological Assessment Resources, Inc.

16204 N. Florida Avenue

Lutz, FL 33549

[www.parinc.com](http://www.parinc.com)

**From:** Kristin Swenson

**Sent:** Wednesday, November 12, 2008 11:29 AM

**To:** Vicki Mark

**Subject:** Permission Request form: EDI-3

Dear Ms. Mark,

I received your direct email from the customer service information desk. I am a graduate student at Smith College's School for Social work and I am writing to seek permission to use the Drive for Thinness Subscale of the EDI-3 on Survey Monkey for a Master's level thesis. Attached is my permission request form for Internet/Web page adaptations, which I also sent via email on Monday, November 10th. Please let me know if you have questions or if you require additional information. Feel free to contact me by email at XXXXXXXXXX or by telephone at XXX-XXX-XXXX. If you could let me know that this message was received, that would be great. I look forward to hearing from you!

Best,

Kristin Swenson

Smith College School for Social Work



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**Kristin Swenson**

**Wed, Nov 12, 2008 at 1:31 PM**

To: Vicki Mark

Hi Ms. Mark,

Thank you for getting back to me. Is it possible to be granted a graduate student discount or am I required to pay the full \$250? Also, is the drive for thinness subscale included in the EDI-RF? If so, is it possible to compare findings on the EDI-RF to findings on the Drive for thinness subscale on previous EDIs? If you could let me know, that would be great!

Thank you!  
Best,  
Kristin Swenson

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**Vicki Mark**

**Wed, Nov 12, 2008 at 2:03 PM**

To: Kristin Swenson

Hello Kristin,

The \$250.00 is a minimum requirement, which means even if you were receiving a graduate student discount on the royalty/license fee – you would still be required to pay the minimum fee. There is no graduate student discount since you are using such a small portion of the EDI-3.

The DT Scale is one of the scales on the EDI-3 Referral Form. The Referral Form contains the Drive for Thinness, Bulimia, and Body Dissatisfaction Subscales. You would be able to compare the DT scores from the Referral Form to the DT Scores on previous EDI-3 or EDI-3 RF administrations. The DT can be scored separately on all forms.

I hope this clears up any confusion. Please let me know how you wish to proceed.

Best Regards,

Vicki

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**Kristin Swenson**

**Wed, Nov 12, 2008 at 2:12 PM**

To: Vicki Mark

Thank you so much for clarifying about the graduate student discount. At this point, I think that I am going to purchase the paper form of the EDI-3 RF to mail in its complete format to participants. Please let me know if I need to fill out any forms to obtain permission to do this. I appreciate all of your help with this process!

Best,  
Kristin Swenson

**Vicki Mark**

To: Kristin Swenson

**Wed, Nov 12, 2008 at 2:37 PM**

No, you wouldn't need permission to mail the forms. You would simply need to purchase the number of forms that you need. However, if you want to include any sample items in your dissertation, then you would need an Agreement with PAR.

Let me know if you want me to prepare an Agreement for the sample items.

Best Regards,

Vicki

APPENDIX H

Chi-Square Analyses

	<i>VALUE</i>	<i>DF</i>	<i>ASYMP. SIG (2 SIDED)</i>
<b>PEARSON CHI-SQUARE</b>	3.592A	2	<b>.166</b>
<b>CONTINUITY CORRECTION</b>			
<b>LIKELIHOOD RATIO</b>	3.691	2	<b>.158</b>
<b>LINEAR-BY- LINEAR ASSOCIATION</b>	.708	1	<b>.400</b>
<b>N OF VALID CASES</b>	34		
	<b>A. 0 CELLS (.0%) HAVE AN EXPECTED COUNT LESS THAN 5. THE MINIMUM EXPECTED COUNT IS 5.18</b>		

APPENDIX I

Drive for Thinness Subscale Overall scores

<i>Valid</i>	<i>Frequency</i>	<i>Percent</i>	<i>Valid Percent</i>	<i>Cumulative Percent</i>
<b>3</b>	1	2.9	3.1	<b>3.1</b>
<b>4</b>	1	2.9	3.1	<b>6.3</b>
<b>5</b>	1	2.9	3.1	<b>9.4</b>
<b>6</b>	1	2.9	3.1	<b>12.5</b>
<b>7</b>	1	2.9	3.1	<b>15.6</b>
<b>8</b>	1	2.9	3.1	<b>18.8</b>
<b>12</b>	1	2.9	3.1	<b>21.9</b>
<b>14</b>	2	5.9	6.3	<b>28.1</b>
<b>16</b>	2	5.9	6.3	<b>34.4</b>
<b>18</b>	2	5.9	6.3	<b>40.6</b>
<b>19</b>	6	17.6	18.8	<b>59.4</b>
<b>20</b>	1	2.9	3.1	<b>62.5</b>
<b>21</b>	2	5.9	6.3	<b>68.8</b>
<b>22</b>	1	2.9	3.1	<b>71.9</b>
<b>23</b>	1	2.9	3.1	<b>75.0</b>
<b>24</b>	4	11.8	12.5	<b>87.5</b>
<b>25</b>	1	2.9	3.1	<b>90.6</b>
<b>26</b>	1	2.9	3.1	<b>93.8</b>
<b>27</b>	1	2.9	3.1	<b>96.9</b>
<b>28</b>	1	2.9	3.1	<b>100.0</b>
<b>Total</b>	32	94.1	100.0	
<b>Missing 999</b>	2	5.9		
<b>Total</b>	<b>34</b>	<b>100.0</b>		

APPENDIX J

Test of Homogeneity of Variances: Drive for Thinness Overall

<i>LEVINE STATISTIC</i>	<i>DF1</i>	<i>DF2</i>	<i>SIG.</i>
<b>.030</b>	<b>2</b>	<b>29</b>	<b>.971</b>

ANOVA: Drive for Thinness Overall

	<i>Sum of Squares</i>	<i>Df</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig.</i>
<b>Between Groups</b>	79.634	2	39.817	.794	<b>.462</b>
<b>Within Groups</b>	1453.866	29	50.133		
<b>Total</b>	<b>1533.500</b>	<b>31</b>			