The Impact of Racial Bias on the Detection of Eating Disorders and Treatment Seeking Rates Among African American Women

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Abstract

Does the race of client effect eating disorder diagnosis and recommendations to seek treatment among women? 500 college students from New Jersey read a passage describing a 16 year old female and her eating habits. The passages differed based on Mary’s race (Caucasian, Hispanic, and African American). Participants answered an eating disorder questionnaire as well as questions about body acceptance and treatment seeking rates. The current study identifies the lack of cultural competence among social workers. The inability or fear to make use of mental health resources is an issue that social workers should be aware of when working with minority populations.

Keywords: Eating Disorder, Racial Bias, Treatment Seeking
Problem Statement

Researchers have found that 3.7 percent, 4.2 percent, and 5 percent of Americans suffer from Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder respectively (National Institute of Mental Health, 2001). Millions of others suffer from eating disorders worldwide. The myth that eating disorders are a “white-girl” phenomenon, affecting only white, middle-upper class, Western women is still perpetuated. Because of this, African American women are thought to be protected from developing eating disorders despite research showing comparable incidence rates between white and black females (Mullholland & Mintz, 2001; Streigel-Moore, Wilfley, Pile, Dohm, & Fairburn, 2000). It is becoming increasingly clear that eating disorders are on the rise throughout the African American community despite the lack of significant diagnoses (White & Grilo, 2005).

Personal practice experience has suggested that a disproportionate number of whites and blacks obtain eating disorder treatment. Over a six month period interning at the University Medical Center at Princeton, only one African American individual was admitted for inpatient care in the eating disorder unit. Similarly, Robergeau, Joseph, and Silber (2006) found that during one year 352 individuals were hospitalized for eating disorders in the state of New York, 279 were Caucasian while only 35 were African American. It is because of this occurrence, and the conflicting research that is available, that further studies are needed which address why the difference in eating disorder diagnoses exists at all.

It is important to study possible reasons why African Americans seem less prone to eating disorder diagnoses in order to help close the very large gap in mental health services. It has been found that African Americans are less likely to seek treatment, and when they do, they go to the emergency room (Satcher, 1999). Because of this, many women are not obtaining the
proper treatment they need. Social justice requires equal access to all opportunities, yet black women are quickly overlooked and lack the ability to access appropriate treatment and proper diagnoses. They are being denied a common human right of unbiased healthcare that many white women are afforded easily.

Understanding cultural differences in eating disorders is important for the social work community as a whole. Social workers should be able to identify common issues and symptoms among all types of populations. This would require them to reduce their bias and engage in cultural competence during practice. Without the development and employment of skills that are culturally relevant individuals within the social work profession would be acting unethically.

If this problem is not addressed then death tolls will rise among young women across the world. In a recent study, mortality rates for AN, BN, and Eating Disorders Not Otherwise Specified (which encompasses all other eating disorders) were 4.0%, 3.9%, and 5.2% respectively (Crow, et al., 2009). Without proper treatment these rates will only increase among all populations. Also, the disparity of health issues found among the African American population will increase without proper attention paid to their medical problems. Stereotypes and assumptions may hinder those in need from receiving proper care and lead many in the black community to distrust the health system even more. Also, the problem of eating disorders may continue to grow exponentially within this community as a way to handle daily trauma. Without the ability, or want, to seek treatment, a community which already must deal with many difficulties will have added another epidemic to their list.

**Literature Review**

Eating disorders are becoming a familiar threat to the livelihood of women across the country. Researchers have found that 3.7 percent, 4.2 percent, and 5 percent of Americans suffer
from Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED), respectively (National Institute of Mental Health, 2001). Millions of others suffer from these disorders worldwide; the mortality rate has reached over 3.5 percent for each specific eating disorder (Crow, et al., 2009). The myth that eating disorders are a “white-girl” phenomenon, affecting only white, middle-upper class, Western women is still perpetuated. Because of this, African American women are thought to be protected from developing eating disorders despite research showing comparable incidence rates between white and black females (Mullholland & Mintz, 2001; Streigel-Moore, Wilfley, Pile, Dohm, & Fairburn, 2000). It is becoming increasingly clear that eating disorders are on the rise throughout the African American community despite the lack of significant diagnoses (White & Grilo, 2005).

Coined the “Golden Girl’s Disease” it is believed that AN, BN, and BED are a response to the Western ideals of beauty (Hill & Fischer, 2008). In white culture, beauty is defined as being light skinned, large breasted, and exceptionally thin. Dieting, a significant precipitant of eating disorders, has become a normative behavior that many women engage in (Barry & Grilo, 2002; White & Grilo, 2005). Due to the internalization of objectifying standards and the belief that being thin and beautiful will help them attain power and success, more and more women have turned to restrictive dieting to help them increase their self-esteem and obtain privileges in their lives (Hill & Fischer, 2008). However, this “normative discontent” that women feel towards their bodies can create more than yo-yo dieting and can lead to the extreme end of the continuum, eating disorders.

These assumptions about white beauty standards help fuel the theory that the cultural components of people of color “protect” them from developing eating disorders. For example, because the black community is said to have a greater acceptance of larger body sizes they are
expected to have less development of eating disorders (Perez & Joiner, 2003). Cultural differences in body size acceptance have been supported by multiple studies citing that ideal body sizes are often larger among black participants than white participants (Perez & Joiner, 2003; Perez, Voelz, Pettit, & Joiner, 2002). Individuals in the black community are, therefore, expected to be able to overlook the cultural ideas of whites that are regularly pushed onto them through the media, television, and advertisements, and follow their traditional beauty standards. However, as they become more acculturated into mainstream American ideals African American women may be more likely to have lower body dissatisfaction and reject their ethnic beauty values.

Current research, however, has suggested that predominantly black communities continue to embrace their own identity. Studies have shown that black adolescents have better self-images, higher self-esteem, less self-consciousness, less body dissatisfaction, and fewer weight concerns compared to their white peers (Perez, Voelz, Pettit, & Joiner, 2002; White & Grilo, 2005). More specifically, White and Grilo (2005) studied 427 female adolescent inpatients admitted to a psychiatric ward for a multitude of eating disorder symptoms in order to study risk factors related to eating disorder maintenance. The majority of patients were Caucasian with about 12 percent describing themselves as African American. The authors found that Caucasian patients had higher levels of dieting and body image dissatisfaction, regardless of other symptoms noted, when compared with African American patients. However, African American girls who did report body image dissatisfaction were more likely to diet than their African American peers. A possible explanation of this is that these African American adolescents have developed more body issues due to acculturation into the white community and, therefore, rely
on mainstream weight-habits such as dieting. However, this was not studied in the research by White and Grilo (2005).

Although these findings coincide with previous research on body dissatisfaction among white and black girls (Barry & Grilo, 2002; Wilfley, Schreiber, Pike, Striegel-Moore, Wright, & Rodin, 1996), White and Grilo (2005) also shed a new light on the subject. They found that while negative self-esteem was the only predictor of body image dissatisfaction among Caucasian adolescents, negative self-esteem, anxiety, and peer influences predicted body image dissatisfaction among African Americans. This shows that there is a more complex interaction of social and psychological risk factors among this population. Although current eating disorder rates appear to be lower among black females than white females it is possible that there are extraneous variables that are not accounted for during diagnosis.

African American women are more likely to be diagnosed with BED as opposed to AN or BN (Streigel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000; Taylor, Caldwell, Baser, Faison, & Jackson, 2007). In a study conducted by Streigel-Moore, Wilfley, Pike, Dohm, and Fairburn (2000) it was discovered that 4.5 percent of the 1,628 black women studied had recurrent binge eating episodes. Similarly, a national survey completed by Taylor, Caldwell, Baser, Faison, and Jackson (2007) interviewed 6,361 African Americans using the WMH Composite International Diagnostic Interview. Their ages ranged from 13-94 years old. It was found that BED was the most common and persistent eating disorder, affecting a little more than 6 percent of the sample studied. This is the most comprehensive study of this group in recent years and provides ample evidence of the prevalence of BED among the African American population. However, conflicting results have also found either more white women developing BED or no variance between ethnicities (Striegel-Moore, et al., 2003; White & Grilo, 2005).
Although these studies reveal the prevalence of BED among African American women they are still less likely to be diagnosed with an eating disorder or receive clinical treatment for it. A possible reason for this is the tendency to focus on AN or BN symptoms only. Because the black community is more likely to develop BED which has entirely different symptoms than other eating disorders it can be difficult to identify it. In a study conducted by Wiseman, Sunday, Klapper, Harris, and Halmi (2001), 1,185 eating disorder patients were studied to understand changing hospitalization rates. It was found that over a 15 year period about 50 percent of individuals, all races included, were hospitalized for AN while 35 percent of individuals were hospitalized for BN. Only 15 percent of patients were diagnosed as Eating Disorder Not Otherwise Specified which included diagnoses of partial AN or BN symptoms as well as BED symptoms. Similarly, Robergeau, Joseph, and Silber (2006) studied hospitalization patterns of eating disorder patients in the state of New York. Of the sample studied, 243 were admitted for AN and 59 were admitted for BN. Only 9.9 percent of these admissions in total were African American. By combining the findings of these studies we can better understand the lack of treatment this population receives in terms of BED diagnoses.

Other factors may impact the low number of African Americans diagnosed with eating disorders. For example, it has been found that African Americans are less likely to seek treatment (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Satcher, 1999), and when they do, they go to the emergency room (Satcher, 1999). This would make it very difficult to diagnose eating disorders among this population since they are not willingly going to the doctor. Also, treatment in the emergency room is often less thorough which could cause many important medical symptoms to be overlooked (Alarcon, 2009).
Minority women with eating disorders are less likely to seek treatment (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001). Reasons identified for not seeking treatment were lack of financial options, fear of being labeled, fear of discrimination, and the counselors being a different ethnicity than the client. Although the study uses a small sample \( n = 61 \), the implications are extremely important. Treatment options for minority women with eating disorders are far and few between. Hospitalization is often very expensive and the fear of discrimination when seeking help, which has been identified as a common issue among the African American population, could lead to under diagnosis or failure to receive treatment once diagnosed.

Clinician bias in terms of diagnosing eating disorders may also lead to under diagnosis (Gordon, Brattole, Wingate, & Joiner, 2006; Gordon, Perez, & Joiner, 2002). Because minority groups are often underrepresented in clinical samples evidence on stereotypes perpetuate that eating disorders are only experienced by white women. Therefore, it is possible that race-based stereotypes and bias influence detection of eating disorders. In order to better understand this, Gordon, Perez, and Joiner (2002) studied 160 undergraduate students. Each participant was given a passage that described the daily activities and eating habits of Mary, a 16-year-old female. The readings only differed by the race of Mary (Caucasian, African American, or Hispanic). Participants were then asked to identify whether or not they thought Mary had any problems and fill out the Eating Disorder Inventory as if they were her. When Mary was Caucasian, 97 percent of participants recognized the eating disorder symptoms. However, when Mary was African American, only 79 percent recognized these symptoms.

In similar research conducted by Gordon, Brattole, Wingate, and Joiner (2006), 22 clinical psychology graduates and 69 trained clinicians were studied. Replication of the previous
study by Gordon, Perez, and Joiner (2002) was completed. It was found that clinicians were more likely to diagnose Mary as having an eating disorder when she was either Caucasian (44.4%) or Hispanic (40.5%). In contrast, Mary was only recognized as having an eating disorder in 16.7 percent of African American cases. These studies combined show that there may be racial biases among both the clinical staff and general population as a whole in terms of eating disorder diagnoses. This provides an important contribution to previous eating disorder research by highlighting the fact that stereotypes often influence our judgment whether we believe ourselves to be culturally competent or not.

The aim of the current study is to further explain why African American women are under diagnosed with eating disorders. Does the race of client effect eating disorder diagnosis and recommendations to seek treatment among women? Acceptance of larger body size among the black community is accounted for. It is predicted that participants will be less likely to diagnose African American women with an eating disorder compared to Caucasian women. It is also predicted that participants will be less likely to recommend seeking mental health treatment for African American women than Caucasian women.

Methods

Research Design

The study will use a cross-sectional, survey research design to explain why African American women are under diagnosed with eating disorders. Quantitative and qualitative data will be collected and then statistically analyzed after coding was completed by researchers. This design was chosen because there is no treatment group or pre-test/post-test available which makes it difficult to have a true experiment. Instead, this design focuses on the relationship between the independent and dependent variables during one session. There is strength in this
design because it allows for a large sample to be studied and is more precise due to standardization of questions. This allows for the study to be generalized to the entire population and creates reliability and validity. It is also useful because it is very inexpensive and does not consume too much time in either the proctoring of the study or the analysis of the study.

**Sampling**

Using probability sampling, and more specifically systematic random sampling, Monmouth University students will randomly be chosen and asked to participate in the study through e-mail. The population that will be generalized is college students (18-40). The sampling frame is students from Monmouth University in all undergraduate and graduate programs. It is anticipated that the study will consist of at least 500 participants.

Identification and access to participants will be granted by a participation agreement from Monmouth University. An alphabetized list of all students in the school will be obtained and every fifth name will be contacted through their e-mail address. Participants will be both men and women as well as ethnically and economically diverse. All participants must speak English.

The sampling method is strong because it allows for random sampling which leads to generalizability of the study. Every student has the same possibility of getting chosen to participate so it removes some biases among the researchers. Also, this sampling method creates a diverse sample because of the use of systematic random sampling.

**Measures**

*Demographics.* The demographics survey asks for specific information such as age, gender, race/ethnicity, and major in school.

*Race of “Mary” in Reading Passage (Independent Variable).* The study operationalizes race as Caucasian, Hispanic, or African American. The vignettes vary based on the race of Mary, the
young girl in the passage, and will be randomly given to participants. The passage has been shown to be reliable and valid through the use of it in previous studies, although no specific statistics are available (Gordon, Brattole, Wingate, & Joiner, 2006; Gordon, Perez, & Joiner, 2002).

Recognition of Eating Disorder (Dependent Variable). Recognition of an eating disorder will be measured through an adapted eating disorder questionnaire by Blakely (2003). A ten question survey will be answered as though the participant was Mary. Operationalization of an eating disorder requires participants to obtain a score of at least 20 or higher on the scale. Questions such as “Do you give too much thought and time to food?” and “Is your weight affecting the way you live your life?” will be answered on a four-point likert scale (1-disagree, 2-somewhat disagree, 3-somewhat agree, 4-agree). Because this scale is adapted there is no reliability or validity data available. Also, self-report questions such as “Mary is experiencing a mental health problem” and “I would consider Mary’s daily eating habits different from the average person” create triangulation between participant’s answers on the eating disorder questionnaire and their own opinions on Mary’s behavior.

Recommendation to Seek Treatment (Dependent Variable). The study uses the question “If I were Mary, I would seek treatment” in order to measure treatment seeking rates. The question will be answered on a four-point likert scale (1-disagree, 2-somewhat disagree, 3-somewhat agree, 4-agree). Also, two qualitative questions, “What barriers might Mary face when seeking treatment” and “Who do you think is most likely to seek mental health treatment,” are being used to measure recommendations to seek treatment and create triangulation. No reliability or validity data is available because these questions were created specifically for this study.
Acceptance of Larger Body Sizes (Mediating Variable). Acceptance of body size among the African American community is measured through two different questions: “African Americans are more accepting of larger body sizes among women” and “Caucasian women need to be thin.” There is no reliability or validity data available as these questions were created for the purpose of the study.

Procedure

Subjects will be recruited through an alphabetized list generated by Monmouth University. Every fifth name on the list will be identified and asked to participate in the study through an e-mail invitation (Appendix D). The students will range in age from 18-40.

All data will be collected by researchers who have been appropriately educated as to how to administer the study. The studies will take place in a classroom on the Monmouth University campus. Ten participants will be tested at one time between the hours of 9am-5pm, Monday-Friday. The expected length of the study is between 15-45 minutes depending on the speed at which participants read. All data will be coded by number and will be kept confidential and anonymous. Surveys and computer data will be locked in a separate room and is only accessible by key researchers for three years. Participants will receive one extra credit point for one class of their choice as previously decided upon in each department at Monmouth University and will have access to the results once analysis is completed.

Upon arrival at the research site on campus participants will be given an informed consent form. The process of informed consent will be orally explained as well and those who provide informed consent with their signature will proceed with the study. The option to quit at anytime will be clearly expressed. Next, all participants will be asked to fill out a demographic sheet (Appendix A). Then, each participant will read a short paragraph about a fictional 16-year-
old female named Mary and her daily eating habits (Appendix B). Each paragraph will differ based on Mary’s race and will be randomly given to each participant. After they have completed the reading each participant will be asked to fill out an eating disorder questionnaire as if they were Mary. They will then be asked to fill out a final questionnaire about recommendations for seeking treatment, body acceptance, and what they thought the study was about. The entire questionnaire can be found in Appendix C. Once the participants have completed all the questionnaires they will be debriefed with a written sheet as well as orally before leaving. Contact information for the researcher, IRB coordinator, and psychological services is given in order to make sure participants experience minimal risks.

Discussion

The aim of the study was to understand why African American women are under diagnosed with eating disorders. Does the race of client effect eating disorder diagnosis and recommendations to seek treatment among women? It was predicted that participants would be less likely to diagnose African American women with an eating disorder compared to Caucasian women. It was also predicted that participants would be less likely to recommend seeking mental health treatment for African American women than Caucasian women.

About 500 participants provided informed consent before participating in the current research. Participants read a passage about the daily eating habits of Mary, a 16 year old girl, who was Caucasian, African American, or Hispanic. They then answered questions about whether or not Mary displayed any mental health issues and if she should seek treatment.

Certain limitations are present in this study. First, the findings may not be generalized to the country as a whole. Because the study was limited to New Jersey college students it is not possible to say whether or not these results would be found among the entire country. In order to
overcome this confounding variable it would be necessary to study individuals from areas across the country including urban cities and more rural areas. Also, participants may not be aware of eating disorder characteristics which would limit their ability to diagnose Mary with an eating disorder. This should be accounted for in future studies in order to have more accurate results.

This study also used a very strong design. The use of previously validated reading passages makes the study reliable and valid. Also, the ability to access such a large sample helps with generalizability to at least the east coast. Using a survey design also creates an easy way to conduct research which provides strength in speed of collection and analysis of the study.

Human rights of the participants were protected at all times. Participants were given the option to discontinue the study at any time. All of their information is kept confidential and will only be accessed by key researchers. Also, all participants were thoroughly made aware of their need for consent and were also debriefed at the end of each study. These processes ensure the rights of each individual are consistently protected.

This study also has many implications for social workers. It identifies the lack of cultural competence in the mental health community. It is clear that racial bias exists in terms of diagnosing specific mental disorders. It also shows that minorities have fewer resources available for them to seek appropriate treatment and get the care that they need. This is important to understand because social workers can use this information to create better assessment programs in order to diagnose women of minority groups with mental health issues and provide them with appropriate resources.

Future studies should focus on a larger population. This is imperative to see if the results would generalize to different parts of the country, both urban and rural areas. Studies should also use different variables such as gender or age to see if these influence detection of the
disorders or treatment seeking rates. By understanding multiple variables that effect the
detection of eating disorders, such as racial bias, we can better help all those who suffer from this
mental health difficulty. This will help close the gap in receiving mental health and broaden the
resources that minority women have access to.
Appendix A

Background Questionnaire

Please answer the following demographic and background questions.

Gender (circle one): Male Female

Age: ________________

Major: ________________

Your race/ethnicity (please be specific, e.g., Italian American, Mexican American, etc.)

Where were you born? (name city/town, state, country)

If you were not born in the United States, at what age did you move to the United States?

What language do you primarily speak at home with other members of your family?
Appendix B

(Gordon, Brattole, Wingate, & Joiner, 2006)

Please read the following passage and then answer the provided questions according to the instructions.

Mary, 16-year-old Caucasian/African American/Hispanic

**Monday:** She woke up and took a shower. Mary tried on three different outfits before choosing what she was going to wear. Did her hair twice before leaving for 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 two 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 two 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 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 two hours and a 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 two 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. She 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 for 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 two 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, salad, and drank some water. Mary watched TV for two hours, talked on the phone for one and a half hours, and then went to bed.

**Thursday:** She woke up and took a shower. She took one 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 two minute presentation in an afternoon class. After school she had soccer practice for two 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 two 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 two 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.
Appendix C

EDS (Eating Disorder Scale) adapted from Blakely (2003)

Please answer each question as if you were Mary. Use the scale below and write the corresponding number in the space provided.

1--------------------2----------------------3----------------------4

Disagree  Somewhat Disagree  Somewhat Agree  Agree

1. Do you go on eating binges for no apparent reason? ______

2. Do you have feelings of guilt and remorse about food and dieting? ______

3. Do you give too much thought and time to food? ______

4. Do you look forward to being able to eat alone? ______

5. Have you purposely starved yourself? ______

6. Have you exercised as a way to control your eating? ______

7. Do you plan secret eating at times? ______

8. Is your weight affecting the way you live your life? ______

9. Does your food obsession make you unhappy? ______

10. Are you a perfectionist, a person who always wants to be in control, an overachiever and/or do you think no matter what you do it is never enough? ______
BITS (Body Image/Treatment Seeking)

Please answer each question based on the scale below. Write the corresponding number in the space provided.

1-------------------2-------------------3-------------------4
Disagree   Somewhat Disagree   Somewhat Agree   Agree

1. I would consider Mary’s daily eating habits different from the average person.  ____
2. Mary is experiencing a mental health problem.  ____
3. If I was Mary, I would seek treatment.  ____
4. African American women are at risk for developing eating disorders.  ____
5. The African American community is more accepting of larger body sizes among women.  ____
6. Caucasian women need to be thin.  ____

Please answer each question with a full response.

1. What barriers might Mary face when seeking treatment?

2. Who do you think is most likely to seek mental health treatment? Please include descriptors such as gender, age, ethnicity, and/or socioeconomic status.
Exit Questionnaire

1. What do you think the study was about?

2. What was the hypothesis of the current study?
References


http://www.drlindablakeley.com/eating_disorders/ed_questionnaire.html


http://www.cdc.gov/omhd/AMH/factsheets/mental.htm


