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Health Care Professionals' Perceptions of Media Influence on Eating Disorder-Related Factors Among African American Women

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Erica Hudson

has been found to be complete and satisfactory in all respects,
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Walden University
2016

Abstract

Health Care Professionals' Perceptions of Media Influence on Eating Disorder-Related Factors Among African American Women

by

Erica Hudson

MA, Argosy University, 2004

BS, Fordham University, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

May 2016

Abstract

Little is known about health care professionals' perceptions of eating disorder etiology among African American (AA) women. The purpose of this quantitative research study was to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. Festigner's social comparison theory; Bandura's social learning theory; and Garcia, Cartwright, Winston, and Borzuchowska's transcultural integrative model served as the theoretical frameworks for this study. Specifically, this study examined whether race and cultural awareness of health care professionals relate to their perceptions of the extent to which media influences AA women's eating disorders, and whether cultural awareness moderates the association between their race and media influences. Data were obtained through a researcher-created demographic questionnaire, the Multicultural Counseling Inventory, and a modified Sociocultural Attitudes Toward Appearance Scale-3 with a purposive sample of 49 participants. Data were analyzed using descriptive statistics, Spearman's Rho correlation, Pearson correlation, and a hierarchical multiple linear regression. Compared to their Caucasian American counterparts, AA health care professionals perceived greater media pressure on AA women's body image concerns. Additionally, participants' cultural awareness was positively correlated with their ratings of AA women's desire to have more athletic bodies. The implications for positive social change stemming from this study are directed at health care professionals as additional training may increase their awareness, early detection, diagnosis, and treatment of eating disorders among AA women.

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Dedication

I would like to dedicate this dissertation in loving memory of my mother, Catherine Frazier, who provided me with the essentials tools of love, hard work, and perseverance. I know, without this basic foundation, I would not be the person I am today.

Acknowledgments

First and foremost, I would like to thank God because without his mercy and grace this would have not been possible. I would like to especially thank my husband, Jerry Hudson, for all of his emotional support. I would like to thank my family and dear friends who continued to believe in me when I no longer believed in myself. Also, I would like to thank my chair, Dr. Kelly Davis, who believed in me as a student. I would also like to acknowledge my committee member, Dr. Heidi Dexter, and my university research reviewer, Dr. Bonnie Nastasi. I will always be grateful.

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Chapter 1: Introduction to the Study

Eating disorders impact 30 million people annually in the United States (National Eating Disorder Association [NEDA], 2016b). This disease has the highest death rate among all other mental illnesses and can lead to sudden death (Arcelus, Mitchell, Wales, & Nielsen, 2011; Levine et al., 2007). Eating disorders can lead to health problems such as an imbalance of electrolytes, reproductive issues, abnormalities in the cardiovascular system, interruption of growth, and bone loss (Reiter & Graves, 2010). Anorexia nervosa is a condition that occurs when a person refuses to maintain weight at or above his or her normal weight, out of a fear of becoming fat, and is in denial about being underweight (American Psychiatric Association [APA], 2013). Having anorexia nervosa may affect one's bone tissue, cardiac function, renal function, and fertility, and it may decrease gray matter, which processes information in the brain (Levine et al., 2007; Robertson, 2014). Bulimia nervosa is a condition that occurs when a person engages in excessive binging, lacks control over food, shows dissatisfaction with body shape and weight, and uses compensatory behaviors, which includes misuse of laxatives, self-induced vomiting, diuretics, and excessive exercising, to eliminate food (APA, 2013). Health risks of bulimia nervosa include erosion on the teeth, nutrient deficiencies, weakness, weight changes, poor concentration, gastroesophageal reflux disease, irregular menstrual cycle, gastrointestinal bleeding, cardiac arrhythmias, and heart palpitations (Rich & Thomas, 2006). Yanover and Thompson (2008) noted that disordered eating behavior can also lead to cognitive impairments in a person's ability to solve problems and perform tasks.

Eating disorders mostly affect women as 20 million women and 10 million men in

the United States suffer from a clinically significant eating disorder at some time in their life, including anorexia nervosa, bulimia nervosa, binge eating disorder, or other specified feeding or eating disorder (OSFED; NEDA, 2016b; Wade, Keski-Rahkonen, & Hudson, 2011). In the United States, the majority of eating disorder research have focused on Caucasian American (CA) women (Taylor, Caldwell, Baser, Faison, & Jackson, 2007). Researchers have not extensively studied the prevalence and incidence of eating disorder diagnosis in African American (AA) women (Mulholland & Mintz, 2001), which may have caused a lack of awareness about eating disorders in AA women. In general, for both CA and AA women, researchers (Harrison & Hefner, 2006; Jeffers, Cotter, Snipes, & Benotsch, 2013; O'Neill, 2003) have examined the impact of media and culture on the development of eating disorders. Halliwell, Dittmar, and Howe (2005) and Stice (2002) noted that media imagery may be related to the development of eating disorder behaviors in CA women. Cultural factors and media exposure that are specific to AA women may account for this group's incidence of eating disorders.

Little is known about how health care professionals, such as counselors, therapist, psychiatrists, and psychologists diganose and treat eating disorders (Mulholland & Mintz, 2001). O'Neill (2003) suggested that health care professionals may unknowingly fail to diagnose eating disorders in AA women because they perceive that eating disorders are mainly a concern for CA women. The NEDA (2016c) reported that minority women are less likely to seek treatment than their CA counterparts, which contributes to the perception of minority women as immune from eating disorders. The NEDA recommended that eating disorder outreach efforts must be attentive to factors affecting

minority populations, including differing worldviews, values, and beliefs; patterns of acculturation; effects of oppression; language barriers; and individual differences within every ethnic and racial group. The media's portrayal of eating disorders may account for some of these misperceptions (O' Neil, 2003). The majority of U.S. media imagery of eating disorders, such as in the news and entertainment programs, depicts CA women (Bowen & Schmid, 1997; NEDA, 2016c). Therefore, there is still much to learn about how eating disorders affect AA women and as noted by the NEDA, additional research is needed in order to ensure that efforts to combat this disorder are inclusive of all women and men.

In this study, I examined the relationships between health care professionals' race, cultural awareness, and perceptions of media influences on eating disorders in AA women. The implications for positive social change are directed at health care professionals to increase their awareness, early detection, diagnosis, and treatment of eating disorders among AA women, which helps AA women receive the care that they need. In Chapter 1, I include the background of the study, problem statement, purpose of the study, and research questions and hypotheses, theoretical framework, nature of the study, operational definition of terms, assumptions, scope and delimitations, limitations, significance of the study, and a summary.

Background of the Study

It is estimated that 20 million women and 10 million men in the United States have an eating disorder (NEDA, 2016b; Wade et al., 2011). NEDA (2016b) reported that CA women have the highest rates of eating disorders. However, Taylor et al. (2007)

suggested that symptoms of eating disorders are becoming more common in AA women. The NEDA (2016a) reported that the rise in eating disorders among women of color may be due to an increase in the reporting of these problems rather than actual increases. The NEDA related that three factors affect the rate of reporting among minority women: (a) underreporting of problems by individuals, (b) under and misdiagnosing on the part of the treatment providers, and (c) cultural bias of Diagnostic and Statistical Manual-IV (DSM-IV) criteria for eating disorders. Data are not available on the number of AA women with an eating disorder each year (Hudson, Hiripi, Pope, & Kessler, 2007; Mulholland & Mintz, 2001; NEDA, 2016b), which has resulting in a gap in the literature. Kelly et al. (2011) suggested that this gap may be due to researchers' use of predominantly CA female samples in their studies. This has created a gap in knowledge due to the inability to know how eating disorders affects AA women. Therefore, there was a need for additional research on eating disorders with a focus on AA women and in this study, I addressed that gap.

When diagnosing whether an AA woman has an eating disorder, health care professionals should take into account cultural factors, such as social behavior, religion, and customs (Kelly et al., 2011; Talleyrand, 2010). The NEDA (2016a) reported that it is sometimes speculated that women from racial and ethnic minority groups are immune to developing eating disorders because their cultural identity provides some amount of protection against body image disturbances. For instance, the NEDA noted that it is frequently asserted that women from AA culture embrace larger body types than women from the CA culture, which makes AA women less prone to body dissatisfaction. Thus,

the NEDA related that it has been hypothesized that as women of color experience acculturation or assimilation of dominant ideals, they become more susceptible to eating disorders. Kempa and Thomas (2000) defined acculturation as "the process of shifting values to the host culture from the culture of origin" (p. 19). Park and Burgess (1924) defined assimilation as "a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons or group; and, by sharing their experience and history, are incorporated with them in a common cultural life" (p. 735). Therefore, researchers noted that therapists need to be familiar with ethnically diverse clients and their respective cultures in order to provide appropriate diagnosis and treatment (Kempa & Thomas, 2000; Root, 1990; Thompson, 1992). Hence, the worldview, values, belief systems, acculturation, and assimilation of AA female clients need to be understood. Subsequently, professionals also need to consider racial differences in working with AA clients who are seeking treatment for eating disorders (Fernandes, Crow, Thuras, & Peterson, 2010). Accordingly, Baugh, Mullis, Hicks, and Peterson (2010) encouraged the development of specific measures to address race differences when examining eating disorders in AA women.

Health care workers must also consider the influence of media content on AA women's body image (Moriarty & Harrison, 2008). Researchers have found a significant correlation between media usage and body perception indicators, such as eating disorder symptomatology, internalization of a thin ideal, and poor body image, all of which may affect the extent to which an individual experiences an eating disorder (Dohnt & Tiggemann, 2006; Groesz, Levine, & Murnen, 2002; Harrison & Hefner, 2006; Levine &

Smolak, 1996; Posavac, Posavac, & Posavac, 1998). Researchers have also found that that media exposure is significantly correlated with disordered eating among adolescents and adults (Harrison & Cantor, 1997; Stice, Schupak-Neuberg, Shaw, & Stein, 1994). Based on media's portrayal of AA women, clinicians may believe that AA women tend to weigh more than CA women and are more satisfied with their weight (NEDA, 2016a), which may lead clinicians to assume that eating disorders are less likely to occur among AA women. The NEDA reported that sociocultural factors, such as pervasive media images that embrace a narrowly defined conception of beauty may be particularly disturbing for some women. Hall (1995) noted that individuals who are furthest from the European standard of beauty; specifically, women of color, may suffer the psychological effects of low self-esteem, poor body image, and eating disorders. Furthermore, Osvold and Sodowsky (1993) found that AA and Native American women who were more accepting of the CA culture showed significantly more symptoms of anorexia and bulimia than individuals who were less accepting.

I believe that eating disorders may be misdiagnosed in AA women due to health care professionals' misperceptions of media's influence and lack of cultural awareness regarding AA women's social customs. In this study, I examined how health care professionals' cultural awareness and race were related to their perceptions of media influence on eating disorders in AA women. Study findings may help health care professionals better understand how biases and stereotypes affect their ability to diagnose and treat AA women with eating disorders so that AA women receive the care that they need.

Problem Statement

Millions of U.S. women and men have eating disorders, and the number of such cases has increased since 1950 (NEDA, 2016b; Wade et al., 2011). Despite knowledge about the serious health risks associated with eating disorders (Levine et al., 2007; Reiter & Graves, 2010; Rich & Thomas, 2006; Yanover & Thompson, 2008), the prevalence of eating disorders in AA women is still unknown (Kelly et al., 2011; NEDA, 2016b). Self-report symptoms on the Eating Disorders Diagnostic Scale (EDDS; Stice & Telch, 2000) are high for minorities (Gentile, Raghavan, Rajah, & Gates, 2007); therefore, I believe that it is important for researchers to include AA women when conducting studies on eating disorders. In doing so, they may be better able to determine whether specific measures are needed to properly diagnose eating disorders in this population.

Moreover, researchers have suggested a possible connection between media exposure and eating disorders (O'Neill, 2003). It is important for health care professionals to understand how eating behaviors and body image may be influenced by media exposure. According to O'Neill (2003), the majority of media portrayals of ideal beauty feature CA women rather than AA women. These representations may ultimately influence health care professionals' misperceptions about eating disorders in AA women. Health care professionals' perceptions may also be influenced by their understanding of a client's cultural values and acculturation as they relate to food and body image (Talleyrand, 2010). In this research study, using Festigner's (1954) social comparison theory (SCT), Bandura's (1977) social learning theory (SLT), and Garcia, Cartwright, Winston, and Borzuchowska's (2003) transcultural integrative model (TIM) for ethical

decision-making, I sought to generate greater knowledge about health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women.

Purpose of the Study

The purpose of this quantitative research study was to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. The dependent variable was health care professionals' perceptions of media influence, and the independent variables were health care professionals' race and cultural awareness. I used survey methods in order to explore three research questions and test related hypotheses.

Research Questions and Hypotheses

In this quantitative research study, I addressed the following research questions and hypotheses:

1. Does the race (CA vs. AA) of health care professionals' relate to their perceptions of the extent to which media influences AA women's eating disorders (as measured separately by each of the 4 subscales of the modified SATAQ-3)?

   $H_0$1: Race has no relationship to the health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

   H_a1: Race does have a relationship to the health care professional's perceptions of the extent to which media influences AA women's eating disorders.

2. Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) relate to health care professionals' perceptions of the extent to which media influences AA women's eating disorders (as measured by the modified SATAQ-3)?

   $H_0$2: Cultural awareness has no relationship to health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

   H_a2: Cultural awareness does have a relationship to health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

3. Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) moderate the potential association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders (as measured by the 4 subscales of the modified SATAQ-3)?

   $H_0$3: Cultural awareness does not moderate the association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders.

   H_a3: Cultural awareness does moderate the association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders.

Theoretical Framework

Festigner's (1954) SCT, Bandura's (1977) SLT, and Garcia et al.'s (2003) TIM for ethical decision-making served as the theoretical frameworks for this study. A brief overview of the theories is provided in this section with a more detailed explanation provided in Chapter 2. I organized this section in the following subsections: social comparison theory, social learning theory, and transcultural integrative model.

Social Comparison Theory

I used SCT to understand the development of eating disorders among AA women and whether AA women differ when compared to CA women. Individuals often compare themselves to others' perceptions of themselves (Festinger, 1954). In addition, they often base their self-image by drawing comparisons to others and then change their behavior to meet that standard (Festinger, 1954). Therefore, health care professionals may not accurately diagnose eating disorders in AA women because they may develop misperceptions of eating disorders in AA women due to media's portrayal of eating disorders and view eating disorders as a problem exclusive to CA women (O' Neill, 2003). In other words, O'Neill (2003) reported that due to the majority of magazine covers and television advertisements consisting mainly of thin CA women, health care professionals may not see weight as a concern for AA women. Therefore, in this study, the SCT was used to understand how AA health care professionals' perceptions compared to CA perceptions about social influences that may affect their decision to diagnose eating disorders in AA women. Corning, Krumm, and Smitham (2006) used the SCT to understand eating disorders. Based on the SCT, disordered eating was more prone

in women who compared and monitored their bodies (Tylka & Sabik, 2010). In this study, I determined if there was a relationship between health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women, as well as how social comparison might influence health care professionals' perceptions by comparing AA and CA health care professionals.

In order to understand disordered eating, perceptions of print media and television must be examined as well (Bamford & Halliwell, 2009). Jefferson and Stake (2009) suggested that AA and CA women develop body dissatisfaction due to European standards of beauty. Dawson-Andoh, Gray, Soto, and Parker (2011) suggested that in magazines geared towards CA women, AA women are not held to the same beauty standards as CA women. It is important to understand how health care professionals view AA women beauty ideals based on media's portrayal. O'Neill (2003) suggested that eating disorders are more likely to be misdiagnosed in AA women due to health care professionals' inability to recognize that eating disorders occur in other women besides CA women. The SCT is discussed in more detail in Chapter 2.

Social Learning Theory

The SLT was used in this research study to understand the importance of media's influence on women's eating disorders. Bandura's (1977) SLT pertains to observational learning and modeling process in which individuals can learn information by watching other people. Bandura explained that SLT includes intrinsic reinforcement, where people may have internal desires such as pride, which may influence learned behavior. People can learn new behaviors without acting out on these new behaviors. In other words,

people generally learn behaviors from watching others through observation and modeling. Bandura suggested that in order for observational learning to be successful, people must be motivation through punishment or reinforcement. Thus, behavioral observation can be enhanced based on the behavior of the model and a negative consequence or reward. Furthermore, Bandura related that reinforcement of model behavior can encourage people to engage in the model behavior through retention. Hence, because media portrayals of beauty primarily focuses on CA women (O'Neill, 2003), health care professionals may learn or perceive that AA women are less concerned about their looks and other eating disorder-related factors than their Caucasian counterparts. SLT was used to examine the relationships among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. This theory is explored in further detail in Chapter 2.

Transcultural Integrative Model

The TIM for ethical decision-making was used to understand how cultural awareness may influence health care professionals' perceptions of eating disorders in AA women. Garcia et al.'s (2003) TIM stems from the foundation of the integrative model of ethical decision-making (Tarvydas, 1998) and includes some aspects of the collaborative model (Davis, 1997) and the social constructivist model (Cottone, 2001). The TIM consists of virtue and principal ethics, which focuses on the character of the counselor and the way they handle challenging ethical decisions (Garcia et al., 2003). For the purpose of this study, the social constructivist model was useful due to the focus of

understanding ethical decision-making when including cultural and social factors (Cottone, 2001).

The TIM was also developed from cognition theory (Maturana, 1980), which takes a relational approach that uses consensus seeking, arbitrating, and negotiating (Garcia et al., 2003). The collaborative model examined decision-making from a group dynamic and collaborative effort (Davis, 1997; Garcia, 2003). Therefore, the TIM, which included aspects of the social constructivist model and the collaborative model, assisted in understanding how health care professionals' race and cultural awareness were related to their perceptions of media influence on eating disorder-related factors in AA women.

The TIM was important in this study due to the emphasis of including cultural factors when making ethical decisions. Culture assisted individuals in the way they analyze and process information in their surroundings as well as beliefs, thoughts, and behavior (Oliveira, 2007). Therefore, cultural factors should be considered when assessing mental illness in clients because counselors have their own acculturation, identity of culture, and values of culture. These cultural factors may shape the view of the counselor in how they handle ethical decisions when working with clients (Garcia et al., 2003). Thus, the perceptions of health care professionals' cultural awareness may impact their view on eating disorders in AA women. The TIM consists of 4 steps: (a) interpreting the situation through awareness and fact-finding, (b) formulating an ethical decision, (c) weighing competing nonmoral values that may interfere with the course of action, and (d) planning and executing the selected course of action (Garcia et al., 2003). This model was used to understand any differences between cultural awareness of AA health care

professionals and CA health care professionals regarding perceptions of media influence on eating disorder-related factors in AA women. This theory is explored in further detail in Chapter 2.

Nature of the Study

In this study, I examined the quantitative relationships among the different variables through the use of survey methodology. The dependent variable was the health care professionals' perceptions of media influence, and the independent variables were health care professionals' race and cultural awareness. Using purposive sampling, I collected data from 55 licensed professional counselors, licensed social workers, licensed psychologists, and psychiatrists in the metropolitan Atlanta, Georgia, area. I included data from 49 participants after excluding individuals who did not meet the inclusion criteria. These professionals had experience in working with women with eating disorders in various settings. These settings included private practice, hospitals, community health agencies, colleges, and universities. The participants consisted of different racial backgrounds, ages, and genders.

I surveyed the participants in this study through the use of a researcher-created demographic survey, the Multicultural Counseling Inventory (MCI), which measures health care professionals' cultural awareness (Sodowsky, Taffe, Gutkin, & Wise 1994), and a modified version of the Sociocultural Attitudes Toward Appearance Scale-3 (modified SATAQ-3), which measures health care professionals' perceptions of media influence on AA women's eating disorders (Thompson, Roehrig, Guarda, & Heinberg, 2004). I collected data through SurveyMonkey and used the Statistical Package for the

Social Sciences (SPSS) to analyze the data, which included descriptive statistics, Spearman's Rho correlation, Pearson correlation, and a hierarchical multiple linear regression analysis. The nature of the study is discussed in further detail in Chapter 3.

Operational Definition of Terms

Anorexia nervosa: A condition that occurs when a person refuses to maintain weight at or above his or her normal weight, out of a fear of becoming fat, and is in denial about being underweight (APA, 2013). There are two types of anorexia nervosa: (a) the restricting type where the person cuts back on food intake and is not engaged in binging or purging behaviors and (b) the binge eating and purging type where the person is engaging in binging and purging behavior (APA, 2013).

Binge eating: A condition that occurs when a person compulsively overeats large amounts of food within a 2-hour period without eliminating the food through purging or laxatives (APA, 2013).

Bulimia nervosa: A condition that occurs when a person engages in excessive binging, lacks control over food, shows dissatisfaction with body shape and weight, and uses compensatory behaviors, which includes misuse of laxatives, self-induced vomiting, diuretics, and excessive exercising, to eliminate food (APA, 2013).

Culture: A person's traditions, viewpoints, customs, and language (Helms & Cook, 1999). "A way of life of a group of people - the behaviors, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next" (Choudhury, 2015, para. 1).

Eating disorders: A mental illness that causes severe disturbances in eating behaviors through starvation, purging, binging, laxatives, and excessive exercise (APA, 2013).

Eating disorders not otherwise specified: A condition that occurs when a person has a combination of symptoms for bulimia nervosa or anorexia nervosa where the person is not meeting full diagnostic criteria for anorexia nervosa or bulimia nervosa (APA, 2013).

Media influence: The phenomenon through which viewing magazines and watching television is thought to shape a person's thoughts on an ideal body type (Harrison, 2006).

Social comparison theory (SCT): Based on this theory, individuals often compare themselves to others' perceptions of themselves (Festinger, 1954).

Social learning theory (SLT): Refers to observational learning and modeling process in which individuals can learn information by watching other people (Bandura, 1977).

Transcultural integrative model (TIM): The TIM consists of virtue and principal ethics, which focuses on the character of the counselor and the way they handle challenging ethical decisions (Garcia et al., 2003).

Assumptions

This research study included several assumptions. It was assumed the instruments used in this study accurately assessed health care professionals' perceptions of media and cultural awareness. The instruments used in this study relied on the health care

professionals to respond to the questions truthfully. It was assumed that the modified SATAQ-3 that was used with health care professionals instead of clients accurately measured health care professionals' perceptions. It was assumed that the participants in this study were honest and provided accurate information based on their knowledge and experience. These assumptions were necessary in order to address the research questions and hypotheses in this study.

Scope and Delimitations

In this study, the sample consisted only of fully licensed social workers, counselors, psychologists, and psychiatrists. The participants were limited to men and women who are AA and CA. I excluded associate level counselors who recently graduated with their Master's degree and were not licensed and health care professionals who were not AA or CA. This study may be generalized outside of the Atlanta, Georgia area to other AA and CA psychiatrists, psychologists, licensed social workers, and licensed professional counselors who have experience in diagnosing and treating eating disorders in AA women. However, finding may not be generalized to nurses and nonlicensed staff members who work with eating disorders in AA women.

Limitations

This study had several limitations such as self-report data, self-selection bias, and research design. Self-reported data may be a limitation to this study in that participants may inaccurately read the instructions prior to completing the assessment or not truthfully answer the questions. One of the instruments used in this study was modified for use with health care professionals rather than clients. In addition, self-selection bias was another

possible limitation in this study due to participants deciding not to participate in the study due to their lack of cultural awareness, race, or other factors. Finally, because the research design relies on correlational data, this study may be limited because it cannot establish casual relationships between the variables.

Significance of the Study

This study may lead to changes in how eating disorders are diagnosed in AA women. Previous research on eating disorders have consisted mostly of CA women samples (O'Neill, 2003). Additionally, the data on the incidence and prevalence rates are nearly nonexistent for AA women (Mulholland & Mintz, 2001). This study investigated how cultural awareness may be related to health care professionals' perceptions of the extent to which the media influences AA women's eating disorders. Hence, this study can serve as a foundation from which to explore other areas such as treatment, early detection, and awareness for AA women with eating disorders.

Summary

In this research study, I examined how health care professionals' race and cultural awareness relate to their perceptions of media influence on eating disorders in AA women. I discussed the overall topic of eating disorders and social change implications for health care professionals when diagnosing eating disorders in AA women. The discussion included several key points such as eating disorders have the highest mortality rate of any other mental illness (Arcelus et al., 2011), and eating disorders have been shown to occur in AA women as well as CA women (NEDA, 2016a; Taylor et al., 2007). Research is limited on how many AA women receive an eating disorder diagnosis. Thus,

the purpose of this study was to understand the relationships among race, cultural awareness, and perceptions of media influence on AA women's eating disorders. Chapter 2 discusses the current literature and statistics regarding eating disorders. It also describes in more detail body image, culture, media influence, and treatment of eating disorders in AA women.

In Chapter 1, I included the introduction, background of the study, problem statement, purpose of the study, and research questions and hypotheses, theoretical framework, nature of the study, operational definition of terms, assumptions, scope and delimitations, limitations, significance of the study, and a summary. In Chapter 2, I include the introduction, literature search strategy, theoretical foundation, understanding eating disorders, statistics and eating disorders, cultural influence on eating disorders in African American women, health care professionals' race and cultural awareness, media influence and eating disorders in African American women, health care professionals' perceptions of media influence, treatment of eating disorders in African American women, quantitative research in eating disorders and African American women, and a summary and conclusions. In Chapter 3, I include the introduction, research design and rationale, methodology, data analysis plan, threats to validity, ethical procedures, and a summary of the chapter. In Chapter 4, I present the introduction, data collection, methodological and statistical assumptions, results, and a summary of the chapter. In Chapter 5, I include the introduction, interpretation of findings, limitations of the study, recommendations, implications, and a conclusion to the study.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative research study was to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. Researchers have extensively studied the causes of, and treatment options for, eating disorders (Reiter & Graves, 2010; Walker & Lloyd, 2011). Media images and communication from family and friends can lead to body dissatisfaction, especially among women (Stice, 2002). Women have higher rates of eating disorders than men (NEDA, 2016b; Wade et al., 2011). The majority of research has been on CA women (O'Neill, 2003). Information on the diagnosis and treatment of eating disorders among AA women is lacking (Taylor et al., 2007). Researchers have not extensively studied the prevalence and incidence of eating disorder diagnosis in AA women (Mulholland & Mintz, 2001), which may have caused a lack of awareness about eating disorders in this group of women. Health professional are often unfamiliar with providing eating disorder treatment to AA women and this inexperience may result in AA women being improperly diagnosed (Taylor et al., 2007). Due to the lack of information on eating disorder diagnosis and treatment in AA women, additional research was needed in this area. Specifically, research was needed that examined health care professionals' race, cultural awareness, and perception of media influence on the development of eating disorders among AA women. In Chapter 2, I include the literature search strategy, theoretical foundation, understanding eating disorders, statistics and eating disorders, cultural influence on eating disorders in African American women,

health care professionals' race and cultural awareness, media influence and eating disorders in African American women, health care professionals' perceptions of media influence, treatment of eating disorders in African American women, quantitative research in eating disorders and African American women, and a summary and conclusions.

Literature Search Strategy

I searched the following Walden University research databases and search engines to find literature for this study: Academic Search Complete Premier, Science Direct, EBSCOhost, ProQuest Central, Thoreau, Mental Measurements Yearbook, Health and Psychosocial Instruments, and Google Scholar. The DSM-5 (5th ed.; APA, 2013) was also reviewed. The key search terms that were used to find articles on this topic were the following: *eating disorders, AA women, women, minorities, media, culture, body image, race, discrimination, therapist, psychologists, psychiatrists, counselors, dieticians, nutrition, bulimia, binge eating, anorexia nervosa, weight, obesity, disordered eating, treatment,* and *quantitative studies*. I used the following combinations of search terms: *eating disorders and women, eating disorders and AA women, eating disorders and AA women, media and eating disorders, body image and AA women, body image and AA women, causes of eating disorders in AA women, cultural influences and eating disorders in AA women, cultural and eating disorders, treatment for eating disorders in minorities, eating disorders and treatment, causes of eating disorders in women, decision theory and eating disorders, influences of eating disorders and women, race and eating disorders, disordered eating in AA women,* and *health care professionals and eating disorders*. Due

a lack of research on eating disorders in AA women, I included peer-reviewed articles from 1989-2013 in the literature review. I also reviewed popular periodicals such as *Newsweek*, resources from professional associations such as the American Psychological Association, and book titles from Chicago Press, Minnesota Press, Sage, Guilford, and Harper Collins.

Theoretical Foundation

Festigner's (1954) SCT, Bandura's (1977) SLT, and Garcia et al.'s (2003) TIM for ethical decision-making served as the theoretical frameworks for this study. I organized this section in the following subsections: social comparison theory, social learning theory, and transcultural integrative model.

Social Comparison Theory

I used SCT in this study to understand clinical decision-making when diagnosing eating disorders in AA women. Festigner's (1954) developed SCT to explain how humans compare themselves to others. The social comparison process outlines how individuals evaluate their abilities and opinions by comparing themselves to others. Corning et al. (2006) noted that when individuals are not able to compare themselves to suitable standards, they take steps to make changes in their environment.

Researchers have used SCT to understand social influences in women who suffer from eating disorders (Bamford & Halliwell, 2009; Corning et al., 2006; Hausenblas, Janelle, Gardner, & Focht 2004; Tylka & Sabik, 2010). Bamford and Halliwell (2009) added to the social comparison literature by investigating early attachment as a factor in increasing social comparison tendencies; hence, the researchers combined these two

previously distinct literatures by using SCT and attachment theory in order to provide a more comprehensive model of eating disorder development. Participants included 213 female undergraduate students from three universities in the United Kingdom. Participants completed a questionnaire. Findings indicated that social comparison mediated the relationship between attachment anxiety and disordered eating. In addition, attachment avoidance was not significantly associated with either internalization of cultural ideals or social comparison, but was significantly related to eating psychopathology. The researchers noted that sociocultural models and media influence may account for disordered eating.

The integration of objectification theory, body comparison, and self-esteem allowed for a broader understanding of objectification (Tylka & Sabik, 2010). Tylka and Sabik (2010) integrated SCT and self-esteem into the objectification theory framework to increase understanding of sexual objectification as it relates to body shame and disordered eating. Participants included 274 women from a mideastern U.S. college, 10.4% of whom were AA (p. 22). The researchers found that disordered eating was more likely to occur in women who compared their bodies to other women.

In order to better understand the cause of eating-disordered behavior, more conclusive cause-effect models that adequately explained the development of eating disorders were needed (Corning et al., 2006). Using SCT as the theoretical foundation, Corning et al. (2006) examined whether differences in social comparison processes were predictive of the presence of eating disorder symptoms in women. Participants included 130 undergraduate women from a midwestern university, who were administered packets

containing stimuli and measures. Findings from the study indicated a greater tendency for women with eating disorder symptoms to take part in every day social comparison. In addition, self-defeating self-appraisals predicted the presence of eating disorder symptoms. Furthermore, the researchers found that self-esteem partially mediated the relationship between body-related social comparisons and eating disorder symptom status.

Mass media, such as print media, movies, and television, impose the strongest sociocultural pressures that affect body image disturbance (Hausenblas et al., 2004). Hausenblas et al. (2004) examined the affective responses of media exposure for 30 CA university women who were either high or low on drive for thinness (DT). Participants completed the Body Dissatisfaction, Bulimia, and Drive for Thinness subscales of the Eating Disorder Inventory-2 (EDI), which assessed the attitudinal and behavioral correlates of eating disorders. Findings indicated that compared to the low DT group, high DT group reported less pleasure while viewing the self-slides, higher negative affect immediately after viewing the self-slides, and higher negative affect 1 and 2 hours after viewing the model slides. In additions, the researchers found that positive affect, when collapsed across group and condition, was lowest at the 1-hour postassessment. Hence, Hausenblas et al. argued that social comparison may lead to an increased DT. Women who had a desire to be thin were more likely to compare themselves to models, which placed them at risk of developing eating disorders. Thus, to help prevent and treat eating disorders, women should eliminate social comparison and improve self-esteem.

A review of the literature indicated that researchers have not yet used SCT to understand how health care professionals may also use social comparisons when working with AA clients who may have eating disorders. Health care professionals who are AA and work with AA clients may have more cultural awareness of AA women clients as it relate to body image and disordered eating behaviors. However, health care professionals who are CA and work with AA clients may lack this cultural awareness because they may not be able to directly compare themselves to AA clients, which may result in them overlooking eating disorder behaviors in AA women. Therefore, I used SCT in order to understand whether health care professionals' race and cultural awareness are related to their perceptions of the extent to which media influences AA women's eating disorders.

Social Learning Theory

In SLT, a different approach is used to examine learned behaviors. According to Bandura (1977), this theory includes a social component where people learn behaviors through modeling. Bandura related that modeling occurs when individuals learn new behaviors and information by observing other people. The modeling process has several key components: (a) attention, where individuals are able to take notice of something or someone of importance in order to learn new information; (b) retention, where individuals are able to recall information; (c) reproduction, where individuals are able to perform behaviors that were learned; and (d) motivation, where individuals have desires to model new behaviors, which may be influenced by reinforcement. Bandura suggested that the majority of behaviors that are learned have occurred either knowingly or unconsciously.

Aggression can be learned through modeling (Bandura, Ross, & Ross, 1961). Bandura et al. (1961) engaged in a Bobo doll experiment, which included 3 to 6 year old children. Bandura et al. used 36 boys and 36 girls in the study and they were placed in three group: (a) a control group, (b) a group that was shown the aggressive models, and (c) a group that was not shown the aggressive models. The children that were shown the model witnessed the model being verbally and physically aggressive toward the Bobo doll through punching, hitting, striking the doll with a mallet, kicking, and throwing the doll in the air. Findings supported Bandura's SLT by demonstrating that the children who were exposed to the aggressive model demonstrated the model's aggressive behaviors, while the children who were not exposed to the model were less aggressive. Findings in the study indicated that behaviors can be learned through modeling and observation.

Researchers have used SLT to explain media's influence (Harrison & Cantor, 1997; Moriarty & Harrison, 2008; Starr & Ferguson, 2012; Stice et al., 1994). Starr and Ferguson (2012) conducted a study with 6 to 9 year old girls to explore self-sexualization based on maternal and media influence. Findings indicated that the sexualized doll was the preferred choice of young girls' ideal self rather than the doll that was not sexualized. The researchers suggested that these findings supported SLT and demonstrated how behaviors can be learned through observation and modeling. Stice et al. (1994) related that eating pathology is related to media exposure. Harrison and Cantor (1997) noted that women's exposure to the media was related to body dissatisfaction, eating disorders symptoms, and DT. These research findings indicated that media can have social influences on body image, which may influence eating disorder behaviors.

In this study, I determined if health care professionals are influenced by the media when diagnosing eating disorders in AA women. CA women beauty standards in magazines tend to be thinner than AA women (Moriarty & Harrison, 2008) and this learned behavior may influence health care professionals' ideal of beauty standards, which may cause them to overlook disordered eating behaviors in AA women. Relative to race and cultural awareness, SLT is imperative to understanding how learned behavior may influence health care professionals' perception of media influence on eating disorders in AA women. Health care professionals who are CA may perceive that eating disorders occurs mostly in CA women based on media influences that generally depict thin CA women on televison and in magazines (Chao et al., 2008). Therefore, SLT provided the framework for understanding the association of health care professionals' race with the perception of media influence on eating disorder-related factors in AA women.

Transcultural Integrative Model

I used the TIM in this study to understand health care professionals' cultural awareness and perceptions of media influence on eating disorders in AA women. The TIM consists of the integrative model, social constructivist's model, collaborative model, and multicultural theory (Garcia et al., 2003). Garcia et al. (2003) developed the TIM in order to incorporate the influences of cultural factors when making ethical decisions. This theoretical framework was appropriate for this research design and was used to understand the relationships of race, media influence, and cultural awareness as they relate to perceptions of media influence on eating disorder-related factors in AA women.

The TIM consists of four steps (Garcia et al., 2003). Garcia et al. (2003) reported that the first step includes fact finding and awareness. In this step, counselors have to be aware of possible ethical dilemmas for all parties involved, which includes awareness of clients' cultural identity and awareness of their own culture and competency in multicultural counseling. The researchers noted that step two consists of formulating ethical decisions by gathering cultural information on clients, reviewing professional ethical codes, and consulting with other professionals who have experience with multiculturalism. Step three consists of weighing competing nonmoral values that may interfere with the course of action. Thus, counselors should be aware of clients' cultural values and determine if clients' culture is not being reflected in treatment due to counselors' nonmoral values. Garcia et al. noted that step four includes planning and executing the selected course of action. In this step, counselors should recognize specific strategies and resources that are appropriate to clients' culture in order to assist with potential barriers such as discrimination, prejudices, stereotypes, and biases. This TIM model can assist counselors in making appropriate ethical decision when cultural barriers may be a hindrance in treatment. Therefore, I chose the TIM in order to understand how cultural awareness may impact the clinical decision making of health care professionals when working with AA women and eating disorders.

The TIM was tested in previous research with rehabilitation counselors, where this model was compared with the rational model (Kitchener, 1984). Garcia, McGuire-Kuletz, Froehlich, and Pooja (2008) examined whether there was a significant difference between participants' ratings of the TIM and the participants' ratings of the ethical

decision-making model. Participants included 60 professionals who provided direct rehabilitation counseling services or related services, and supervisors. Garcia et al. found no significant difference between the two groups; hence, both models were effective.

Clinicians are faced with ethical dilemmas when treating clients with eating disorders (Matusek & Wright, 2010). Using the TIM, Matusek and Wright (2010) provided an overview of challenging ethical questions relevant to medical, nutritional, and psychological treatment of clients with eating disorders including imposed treatment, enforced feeding, the duty to protect minors and adults, the determination of competence and capacity among medically comprised clients, and the effectiveness of coercive treatment for clients with eating disorders. The researchers suggested that the TIM was helpful when working with clients with eating disorders when faced with ethical dilemmas such as competency, duty to protect, non-maleficence, and autonomy. The TIM is relatively new and has been adapted from the integrative model by adding cultural implications to assist with ethical decision making. Therefore, I chose this model as one of the theoretical framework for this research study in order to examine whether health care professional's cultural awareness was related to their perception of eating disorders based on media influence in AA women.

Understanding Eating Disorders

Eating disorders are mental illnesses that are thought to occur mostly in middle-class CA women (Talleyrand, 2006). The various types of eating disorders include anorexia, bulimia, and binge eating disorders (Polivy & Herman, 2002). Eating disorders can cause mental and physical health issues such as depression, low self-esteem, suicide,

obesity, infertility, and malnutrition (Polivy & Herman, 2002). According to the APA (2013), anorexia is defined as an eating disorder characterized by individuals' refusal to maintain their body weight through the use of excessive dieting and inaccurate perceptions of their body image based on obsessive fears of becoming fat. The APA noted that bulimia pertains to individuals' extreme rapid binging followed by purging through self-induced vomiting, laxatives, diuretics, restrained eating, or too much exercise. The APA related that binge eating disorders are defined as binge eating that is uncontrolled without the abuse of laxatives and vomiting. In addition, the APA reported that eating disorder not otherwise specified (NOS) is a type of eating disorder where a person does not meet full criteria for anorexia nervosa or bulimia, and instead has symptoms of both eating disorders.

The prevalence of binge eating disorders and obesity has increased in the past 20 years in AA women (Talleyrand, 2006). Binge eating disorders appear the same as or more frequently in AA women as in CA women (Taylor et al., 2007). AA women with binge eating purge more often and weigh more compared to CA women (Pike et al., 2001). Binge eating disorders in AA adolescents and adults are more prevalent than anorexia (Taylor et al., 2007). Muholland and Mintz (2001) conducted a study on diagnosing eating disorders in AAs and found that 2% were diagnosed with eating disorders NOS and no other eating disorders were diagnosed using the DSM-IV criteria. Gentile et al. (2007) conducted a study using college freshman women who were given the Eating Disorders Diagnostic Scale. Findings indicated that when eating disorders were self-reported in minorities, they were higher than in CA men and women. Taylor et

al. (2007) claimed that clinicians may need more training to detect eating disorders in other populations apart from CAs. Thus, clinicians need to consider cultural factors, gender, and onset of age in the AA population as well.

Several factors can lead to eating disorders. Gentile et al. (2007) reported that abuse, including physical and sexual abuse, are one of the risk factors for eating disorders. Blue (2011) related that internalization of the thin ideal, body dissatisfaction, and family members' complaints about an individual's weight are predictors of eating disorders; thus, eating disorder clients may be influenced through social learning and reinforcement. Other predictors of eating disorders include body monitoring (Mitchell & Mazzeo, 2009), comparing oneself to a celebrity (Shorter, Brown, Quinton, & Hinton, 2008), social comparison to others, and low self-esteem (Corning, Krumm, & Smitham, 2006). Therefore, clients may be influenced by media by comparing themselves to others, which is in line with SCT.

Statistics and Eating Disorders

The majority of data that have been gathered on eating disorders have been mainly on CA American women. However, there has been an increase in disordered eating in different racial groups (Neumark-Sztainer et al., 1996). Villarosa (1994) examined the prevalence of eating disorders symptoms, such as the fear of being overweight and the desire to be thin, in AA women and found that 71.5% of the participants wanted to be thinner and 64.5% were obsessed with body fat. Striegel-Moore et al. (2000) found that eating disorders inventory results were higher in AA girls compared to CA girls. Kelly et al. (2011) found that risk and symptomology of eating

disorders were not the same for AA women and CA women when using various tests and measurements on eating disorders and body satisfaction. Kelly et al. noted that the majority of test and measures that were conducted consisted of CA with focused on body dissatisfaction, thin-ideal internalization, and dieting. The researchers argued that these risk factors are not as primary when assessing eating disorders in AA women because AA women tend to be at a greater risk for binge eating. Striegel-Moore et al. reported that binge eating behaviors are more prevalent in AA girls than CA girls. Mulholland and Mintz (2001) noted that AA women are developing eating disorders at a higher rate than in the past. However, the researchers noted that research data are lacking on how many new cases of eating disorders occur and the overall eating disorder rate among AA women. Thus, NEDA (2005) noted that reporting bias in research has made it difficult to estimate eating disorders in women of color.

Cultural bias plays a key role in testing for eating disorders as the majority of test measurements used are for CA samples (O'Neill, 2003). O'Neill (2003) reported that eating disorders may not be considered for AA female patients by health care professionals due to the assumption that eating disorders occur mostly in CA women. Hence, health care professionals' biases may result in health issues for minority groups who suffer from eating disorders. Subsequently, there is a need to have data on AA women to better assist with early intervention due to the health risks associated with eating disorders.

There are several possible factors that attributed to the lack of data on eating disorders in AA women. First, the sample size used in previous research studies on eating

disorders was a factor. Researchers such as Baird, Morrison, and Sleigh (2007), Demarest and Allen (2000), Gordon, Castro, Sitnikov, and Holm-Denoma (2010); and Mulholland and Mintz (2001), all used large sample sizes of AA women. However, Fernandes et al. (2010); Heinberg and Thompson (1992), Lokken, Worthy, Ferraro, and Attmann, (2008), Rich and Thomas (2008), and Sabik, Cole, and Ward (2010), used small sample sizes of AA women: Inadequate AA women sample sizes resulted in a gap in the literature on research in eating disorders in AA women.

Furthermore, the lack of data on AA female eating disorders may be due the DSM-IV diagnosing criteria, lack of client disclosure, and improper diagnosis (NEDA, 2005). According to Hudson et al. (2007), there is no mention of race for the 12 month prevalence for eating disorders in women in national surveys. This makes it difficult to determine if eating disorders are being diagnosed in AA women when race is not listed in the data. This is a problem for AA women who may have an eating disorder, but due to lack of data, health care professionals may not consider this a risk for AA women.

Cultural Influence on Eating Disorders in African American Women

It is important to understand the role cultural influences have on eating disorders in AA women from a historical standpoint, which includes taking on nontraditional roles in the household by being the provider and head of the household. Malson, Mudimbe-Boyi, O'Barr, and Wyer (1990) reported that this nontraditional role was due to the absence of AA men in the household during the era of slavery and postreconstruction. Geller, Garfinkel, Cooper, and Mincy (2009) related that as of a result of AA men being incarcerated, AA women continue to be heads of the household. Green (1994) noted that

while providing both the traditional male and female roles in the household, AA women tend to neglect themselves by looking after others first and have been depicted as survivors. Self-neglect may result in AA women making unhealthy eating choices. Talleyrand (2010) noted other factors that may affect AA women such as racial identity, acculturation, and socioeconomic status.

Traditional research and counseling services that are used to assess eating disorders in women do not incorporate risk factors that are associated specifically with AA women despite the high rates of binge-eating behaviors and obesity within the AA women community (Talleyrand, 2006). Talleyrand (2006) related that stressors such as discrimination, racial biases, cultural differences, acculturation, and societal pressures need to be considered in order to understand how and why AA women may develop anorexia, bulimia, and binge eating disorders. Therefore, when health care professionals are performing assessments on AA women, they should take into account these cultural factors.

Other cultural influences that affect AA women and their body image include classism and socioeconomic status. Green (1994) noted that AA women may experience racism and sexism where they may not have the same access to employment as CA men and women and AA men in positions of power. Therefore, AA women may believe that they have to adapt to CA cultural standards and may feel pressured to look a certain way in order to be accepted in the dominant culture (Ofosu et al., 1998; Root, 1990). However, middle-class AA women are at a greater risk for developing anorexia nervosa and bulimia due to their socioeconomic status and adapting to CA middle-class values

(Polivy & Herman, 2002). O'Neill (2003) noted that as AA women move up in social class, they become prone to eating disorders, similar to CA women. In contrast, O'Neill related that AA women with lower socioeconomic status tend to be at a greater risk for obesity. Therefore, AA women, regardless of social class, are prone to disordered eating behaviors. Thus, as health care professionals diagnose eating disorders in AA women, it is important that they consider not only culture and race, but also socioeconomic status.

Racial discrimination can lead to eating disorders in AA women and girls. Landrine and Klonoff (1996) reported that racial discrimination can have a negative effect on physical and mental health. Hesse-Biber, Livingstone, Ramirez, Barko, and Johnson (2010) related that body image and racial identity are shaped through school and family in early development. However, O'Neill (2003) noted that researchers have not yet established how racism may affect the development of eating disorders. Discrimination may lead to disordered eating; thus, health care professionals should consider the factors discussed when working with the AA women population.

Food is an important expression of culture for AAs. Thompson (1994) noted that food plays a role in the AA culture by providing social forms of comfort. The researcher noted the importance of food in several social activities such as family gatherings, church events, holidays, and Sunday dinners. Thompson noted that when food is unavailable at home, fast food becomes an option. In addition, AA women tend to use food in times of happiness, sadness, grief, and life's unpredictable challenges. Therefore, Henrickson et al. (2010) related that understanding differences in eating behaviors and race differences are important when examining eating attitudes in women.

Health Care Professionals' Race and Cultural Awareness

It is important that health care professionals who work with minority clients are aware of their own cultural stereotypes, biases, and race in order to understand their clients' worldviews as this will help them to use appropriate counseling skills that are culturally relevant to clients. Sue, Arredondo, and McDavis (1992) noted that health care professionals' awareness will help them to establish a therapeutic relationship with their clients and ensure an appropriate counseling environment in which clients feel safe to disclose possible disordered eating behaviors. O'Neill (2003) suggested that health care professional's may be biased when diagnosing eating disorders in AA women because most media portrayals of ideal beauty consisted of CA women. Hence, it is important to understand how the health care professionals' race and cultural awareness may influence their perception of eating disorders in AA women.

As health care professional discuss eating patterns and body image with clients, health care professional should be knowledgeable about clients' assimilated specific cultural values (Talleyrand, 2010). Talleyrand (2010) related that health care professionals should know clients' level of acculturation in regard to clients' attitudes on body image and food. Therefore, cultural awareness of the health care professional is critical to understanding how professionals' perceptions of media influences AA women's eating disorders.

Media Influence and Eating Disorders in African American Women

Global pressures to be thin, primarily stemming from celebrities in television and magazines, influence eating behaviors (Chao et al., 2008). Silverstein, Perdue, Peterson,

and Kelly (1986) noted that media images generally portray women as thinner than in the past. According to Perkins (1996), thin CA women are depicted as the ideal beauty standard, which negatively affects women of color. Mastro and Greenberg (2000) related that television stars and images on the cover of magazines set beauty standards, and AA women images are often missing. It is estimated that only 5.6 % of primetime television actors are AA (Mastro & Greenberg, 2000) and only 2% to 3% of major magazine covers consist of AA images (Bowen & Schmid, 1997). Shorter et al. (2008) reported that disordered eating might be connected to a social standard that results from a comparison of self to celebrities. Stice (2002) noted that media images can lead to body dissatisfaction. Hence, media may have an influence on eating disorders in AA women because the majority of women depicted in mass media are of CA descent with low body mass indexes (BMIs).

To best understand eating disorders, researchers should examine the developmental perspective that includes the adolescent years. Hudson et al. (2007) claimed that the typical age of onset is 19 years old for anorexia nervosa, 20 years old for bulimia nervosa, and 25 years old for binge eating disorder. The awareness of body images is formed during the adolescent years and can carry into womanhood (Striegel-Moore & Bulik, 2007). According to Duke (2002), AA adolescent girls are dealing with their changing bodies, the pressure to conform to society's ideal of beauty, and the challenges of racial identity. Moriarty and Harrison (2008) examined AA and CA adolescent girls and body image and found that exposure to television was a predictor for disordered eating in the girls 12 months later. Moriarty and Harrison (2008) also

suggested that television viewing was a better prediction for an idealization of the unhealthy BMI body type shown in magazines. These findings suggested there is a relationship between media influence and eating disorders.

For preadolescent girls, television viewing of an unhealthy BMI ideal adult body type could lead to disordered eating behaviors (Harrison & Hefner, 2006). Schooler et al. (2004) conducted a study with 584 CA women and 87 AA women. Findings indicated that AA women did not have a negative reaction when they viewed AA or CA women on television. However, this study sample size for AA women was small and findings contradicted other research on media influence and eating disorders. Moriarty and Harrison (2008) reported that disordered eating in girls should be furthered explored, regardless of race, in order to understand how television viewing can affect disordered eating in girls. Understanding how media can shape body image and eating behaviors in young girls can assist health care professionals when working with clients who have eating disorders.

Print media images can also influence body image. Dawson-Andoh et al. (2011) found that in magazines that cater to AAs, the body shape and size of AA women's hip and waist were larger compared to CAs in magazines. Dawson-Andoh et al. also found that AA woman's body size did not conform to the ideal depicted in CA print standards. Thompson, Boisseau, and Paul (2011) noted that Ebony magazine, which caters to AAs, had models that mostly consisted of average and fuller figure sizes. Halliwell et al. (2005) related that models that were of average size were more relatable to women who were concerned about their body image. Women were able to relate to models that were more

of a reflection of them, which is an average-sized woman.

The media may indirectly influence body dissatisfaction based on racial identity in AA women. According to Zhang (2009), AA women with strong race identity had less desire for thinness and body dissatisfaction. However, the researcher noted that AA women who did not have strong race identity, desired thinness and had body dissatisfaction. Thus, race identity has an effect on how media images influence disordered eating behaviors in AA women.

Health Care Professionals' Perceptions of Media Influence

Media consist of print, magazines, and television. According to Anastasio, Rose, and Chapman (1999), media may influence people's view of reality because they are the main source through which people see the world. Anastasio et al. noted that people's view may be altered by media if what is projecting is not reflective of reality. Hence, the authors noted that media are powerful tools that have a major influence on the culture of the United States due to its expression of entertainment and news. Given the previously established association between the media and eating disorders, it is likely that health care professionals are aware of the influence of the media on clients' development of eating disorders. However, to date, there are no empirical research on how health care professionals perceive media influence based on clients' race. Furthermore, there is no research on how a health care professionals' race might be associated with their perceptions of the way in which the media influences eating disorders in AA women. This study was the first to examine if CA health care professionals and AA health care professionals differ in their perceptions of media's influence on eating disorders in AA

women.

Treatment for Eating Disorders in African American Women

Many health care professionals have acquired the proper education and training in working with individuals who suffer from eating disorders, such as how to diagnose and provide treatment. However, some health care professionals lack knowledge about the treatment and causes of eating disorders (Walker & Lloyd, 2011). Health care professionals must ensure that clients receive proper treatment from a team of professionals who will be able to recognize the causes and risks associated with eating disorders (Reiter & Graves, 2010). These guidelines include knowledge regarding negative body image; ideals of beauty; cultural factors; physical activities; social pressure from athletics, school, or work; eating habits; and psychological factors (Reiter & Graves, 2010). Treatment for eating disorders in AA women may be different from that of CA women for several reasons such as AA women may not take their symptoms seriously, they may be uncomfortable in sharing, and they may not know that there is help for their disordered eating behaviors (Ofosu et al., 1998). For example, AA women may feel that their eating behaviors are normal and that there is no need to share this information with health care professional.

In addition, eating disorders can be underreported in AA women because they lack finances to seek medical care and there is a lack of AA therapists (Ofosu et al., 1998). Hackler, Vogel, and Wade (2010) examined self-stigma and seeking counseling for disordered eating in college students and found that another barrier included a lack of information on how the counseling process worked. Therefore, health care professionals

must be educated on the barriers AA women face in seeking treatment for eating disorders. When health care professionals become aware of these barriers, they can provide education on eating disorders in AA communities in order to encourage AA women to seek treatment.

Health care professionals may help with these barriers by understanding the treatment process of eating disorders. First, Newell (2010) reported that health care professionals must understand that being met with resistance is a part of the therapeutic process. Second, Newell noted that health care professionals must employ motivation for change as well as have empathy toward clients. Third, Treasure (2006) related that the treatment for eating disorders can be enhanced by looking at the individual needs of each client. Gilbert et al. (2012) found that as women become older, they are more likely to open up and share their disordered eating behaviors. Therefore, the researchers noted that self-disclosure is beneficial when providing treatment for eating disorders. Gilbert et al. suggested that clients may be more comfortable in opening up to their therapist if the therapist self-disclose in order to help build the therapeutic relationship. Newell (2010) related that providing support for patients' families result in better treatment outcomes for patients. Hence, health care professionals should understand treatment barriers and be knowledgeable about eating disorders when treating women with eating disorders.

Health care professionals may also struggle with the recommended weight gain that is sometimes needed when treating clients with eating disorders. Reiter and Graves (2010) reported that when assessing target weights for patients who suffer from eating disorders, it is important to restore appropriate weight to decrease the risk of the

continued disordered eating behavior. However, the researchers noted that this can be a challenge for some professionals due to variations of normal weight based on genetics. Shah et al. (2010) related that some AA women may not be able to appropriately identify a correct serving size; therefore, when treating eating disorders in AA women, it is important to understand how body weight, food intake, and knowledge of serving size differ among clients from different racial backgrounds.

It is important to understand cultural differences and the influence of food in the AA culture in order to better assess and provide treatment in this population (Cage, Cobb, English, & Kluck, 2010). Cage et al. (2010) noted that health care professionals need awareness on how food is a central focus for some AA women and how being overweight is considered normal for some AA women. Williams and Haverkamp (2010) reported that when treating clients with eating disorders, mental health professionals should obtain additional training in human physiological function and nutrition apart from the training they received in the traditional classroom settings. Thus, the treatment of eating disorders in AA women can be a challenge for health care professionals due to mental and nutritional factors.

Quantitative Research in Eating Disorders and African American Women

The majority of research have been conducted on clients with eating disorders and not on health care professionals who treat this disorder, resulting in a knowledge gap of health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women. There is also a lack of literature on eating disorders in which the the particpants were health care professionals. However, I was able to locate

one study in which the particpants were health care professionals. Shisslak, Gray, and Crago (1989) examined how health care professionals were affected when treating clients with eating disorders. Participants included 58 female professionals and 13 male professionals. The sample size included 17 psychologists, two psychatrists, three physicans, 25 psychartric nurses, six counselors, five social workers, seven nutritionists, and six other professionals. The participants completed a questionare that consisted of demographic data, questions on eating patterns, and history of dieting and weight. Researchers found that 28% of the health care professionals were affected when working with this population by improving their own eating habits and increased awareness of physical appearance, food, and exercise.

The lack of focus on health care professionals in eating disorder studies has resulted in a gap in the literature in understanding how health care professionals diganose and treat eating disorders. This study is the first to examine the relationships among race, cultural awareness, and preception of media influence on eating disorders in AA women. Participants consisted of mental health professionals, including licensed professional counselors, licensed social workers, licensed psychologists, and psychiatrists. The design of this stuudy is discussed further in Chapter 3.

Summary and Conclusions

There has been a great deal of research done on CA females in reference to eating disorders. This has allowed health care professionals to obtain the needed knowledge to assist in the prevention, diagnosis, and treatment of eating disorders in CA women. However, there is a lack of research on incidence and prevalence of eating disorders in

AA women (Mulholland & Mintz, 2001). The media, including print and television media, may negatively affect women's self-image as they may want to fit the ideal beauty standard based on society and mainstream media. AA women may feel pressured to look like the ideal CA woman, which may result in AA women developing eating disorders. Furthermore, health care professionals are not immune to cultural and media influences, and these influences can unknowingly play a role in their clinical decision making. Therefore, a better understanding of how cultural and media influence may impact clinical decision making of health care professionals is critical to the early detection and treatment of eating disorders in AA women.

In Chapter 2, I included the introduction, literature search strategy, theoretical foundation, understanding eating disorders, statistics and eating disorders, cultural influence on eating disorders in African American women, health care professionals' race and cultural awareness, media influence and eating disorders in African American women, health care professionals' perceptions of media influence, treatment of eating disorders in African American women, quantitative research in eating disorders and African American women, and a summary and conclusions. In Chapter 3, I include the introduction, research design and rationale, methodology, data analysis plan, threats to validity, ethical procedures, and a summary of the chapter. In Chapter 4, I present the introduction, data collection, methodological and statistical assumptions, results, and a summary of the chapter. In Chapter 5, I include the introduction, interpretation of findings, limitations of the study, recommendations, implications, and a conclusion to the study.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the relationships among health care professionals' race and cultural awareness and their perceptions of media influence on eating disorders in AA women. Using purposive sampling, I collected data from 55 licensed professional counselors, licensed social workers, licensed psychologists, and psychiatrists in the metropolitan Atlanta, Georgia, area. I included data from 49 participants after excluding individuals who did not meet the inclusion criteria. I surveyed the participants in this study through the use of a researcher-created demographic survey, the MCI (Sodowsky, Taffe, Gutkin, & Wise 1994), and a modified SATAQ-3 (Thompson et al., 2004). Data were collected through SurveyMonkey. Data were analyzed using SPSS. The study was conducted in accordance with Walden University's Institutional Review Board (IRB) guidelines to ensure the ethical protection of research participants. The IRB approved the application for the study and the approval number is 10-21-14-0042289. In Chapter 3, I include the research design and rationale, methodology, data analysis plan, threats to validity, ethical procedures, and a summary of the chapter.

Research Design and Rationale

In this quantitative research method, I used a survey design, which was appropriate for this study as the goal was to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. Johnson (2006) noted that quantitative research,

such as survey designs, have many strengths, such as obtaining data that allow quantitative predictions to be made, data collection is relatively quick, data analysis is less time consuming, the research results are independent of the researcher, and it is useful for studying large numbers of people. In this research study, the independent variables were race and cultural awareness, and the dependent variable was perception of media influence. I surveyed the participants in this study through the use of a researcher-created demographic survey; the MCI (Sodowsky, Taffe, Gutkin, & Wise 1994), which uses a 4-point Likert scale format; and a modified SATAQ-3, which uses a 5-point Likert scale format (Thompson et al., 2004). Likert scales are useful for data collection where I used fixed choice response formats that are designed to measure attitudes or opinions (Bowling, 1997; Burns & Grove, 1997). These ordinal scales measure levels of agreement and disagreement and are easy to understand (McLeod, 2008). McLeod (2008) reported that Likert-type scales assume that the strength or intensity of experience is linear or on a continuum from strongly agree to strongly disagree, and makes the assumption that attitudes can be measured.

Methodology

In this section, I discussed the methodology. Sufficient depth was provided so that other researchers can replicate the study. This section is organized in the following subsections: population; sampling and sampling procedures; procedures for recruitment, participation, and data collection; instrumentation and operationalization of constructs.

Population

Licensed AA and CA psychiatrists, psychologists, professional counselors, and clinical social workers practicing in the metropolitan Atlanta, Georgia, area constituted my target population. The sample consisted of a purposive sample of 55 volunteer participants. I included data from 49 participants after excluding individuals who did not meet the inclusion criteria. I recruited participants from mental health state agencies, private practices, private hospitals, and state hospitals in Georgia. I also recruited participants through the psychologytoday.com website from the trade publication *Psychology Today*. In addition, I recruited participants through the State of Georgia License Board and the Licensing Professional Counseling Association for Georgia.

Sampling and Sampling Procedures

The sample population for this study consisted of participants from the metropolitan Atlanta, Georgia, area. To be included in the study, participants had be licensed AA and CA psychiatrists, psychologists, professional counselors, and clinical social workers and have experience conducting assessments and diagnosing and treating clients with eating disorders. I excluded associate level health care professionals because they were not fully licensed and were not able to practice without supervision. In addition, I excluded health care professionals who had no experience working with clients who have eating disorders. I used G*Power 3.1.9.2 to assess the required sample size. Using a medium effect size (d = 0.50), a generally accepted power of .80 is recommended when doing a t test for means (Sawyer, 1982); thus, a power level of 0.8 was used, and an alpha level of .05, the required sample size was 55. I determined that

this number was an appropriate sample size based on guidelines for calculating alpha and power levels (Gravetter & Wallnau, 2009).

Procedures for Recruitment, Participation, and Data Collection

I completed the National Institutes of Health (NIH) Human Research Protections training prior to data collection (see Appendix G). In addition, I complied with all U.S. federal and state regulations, which included informing participants about the level of anonymity in the study through the use of the consent form. I began data collection after receiving approval to conduct the study from the Walden University IRB.

Through the use of e-mail addresses that I obtained from the State of Georgia License Board and the Licensing Professional Counseling Association for Georgia, I recruited participants from these organizations as well as other mental health state agencies, private practices, private hospitals, and state hospitals in Georgia. I also recruited participants through the psychologytoday.com website from the trade publication *Psychology Today*. I contacted potential participants through e-mail and informed them that I am a Walden University doctoral student and I was conducting research and collecting data for a research study on eating disorders for my dissertation. Through e-mail, I invited potential participants to participate in the study by going to the SurveyMonkey link and I gave them an electronic consent form to keep (see Appendix A). By completing the demographic questionnaire and the two surveys on SurveyMonkey, participants gave their implied consent as signed consent was not obtained. Therefore, participants' identities were anonymous and I did not do exit interviews or follow-ups.

Instrumentation and Operationalization of Constructs

The research instruments consisted of a researcher-created demographic questionnaire; the SATAQ-3 (Thompson et al., 2004), which I modified; and the MCI (Sodowsky et al., 1994). I collected data on each participant's race, age, gender, license type, and years of clinical experience working with clients with eating disorders, and type of work place. The participants self-reported each demographic variable. I used the demographic to provide descriptive statistics of the sample as well as the independent variable, participant race, and to screen participants through the inclusion criteria (see Appendix C).

The SATAQ-3 included four subscales: Internalization-Athlete, Pressures, Information, and Internalization-General (Thompson et al., 2004; see Appendix D for the modified SATAQ-3 and Appendix E for the permission to use, modify, and reprint the SATAQ-3). I used these subscales to measure the dependent variable; specifically, participants' perceptions of media influence on AA women's eating disorders. The MCI consisted of four subscales: Multicultural Knowledge, Multicultural Awareness, Multicultural Counseling Relationship, and Multicultural Counseling Skills (Sodowsky et al., 1994). I used these subscales to measure the independent variable; specifically, cultural awareness. The MCI was not included in the Appendices because of copyright regulations; however, see Appendix F for the permission to use the MCI. The MCI and the SATAQ-3 are discussed in further detail below.

Multicultural Counseling Inventory. The MCI (Sodowsky et al., 1994) was used as a measure of health care professionals' cultural awareness. This is a 40-item

measure that Sodowsky et al. (1994) developed to examine multicultural knowledge, multicultural awareness, multicultural counseling relationship, and multicultural counseling skills in counselors, psychologists, and psychology students. This measure was relevant to this study because the participants are health care professionals and I examined cultural awareness in these participants.

The Multicultural Knowledge subscale consisted of 11 items, such as "When working with minority clients, I apply the sociopolitical history of the clients' respective minority groups to understand them better". The Multicultural Awareness subscale consisted of 10 items, such as "I am involved in advocacy efforts against institutional barriers in mental health services for minority clients". The Multicultural Counseling Relationship subscale consisted of 8 items, including "When working with minority clients, I am confident that my conceptualization of client problems do not consist of stereotypes and biases". Finally, the Multicultural Counseling Skills subscale consisted of 11 items, such as "When working with minority clients, I am able to quickly recognize and recover from cultural mistakes or misunderstanding". These subscales were measured on a 4-point scale ranging from 1 (*very inaccurate*) to 4 (*very accurate*).

The MCI internal consistency reliabilities were .81 on the multicultural counseling skills, .80 on multicultural knowledge, .80 on multicultural awareness, and .67 on multicultural relationships (Sodowsky et al., 1994). Pope-Davis and Dings (1994) compared the Multicultural Counseling Awareness Scale (Ponterotto, Rieger, Barrett, & Sparks, 1994) to the MCI (Sodowski et al., 1994) in order to examine the empirical findings on content validity between these two measures. The study results were shown

to be consistent with the initial findings of Sodowsky et al. (1994) with the MCI correlations ranged from r = .19 to r = .54, and the coefficient alpha reliabilities ranged from .76 and .63. Previous researcher who have used this measure (e.g., Constantine & Ladney, 2000; Green et al., 2005; Middleton et al., 2005; Ottavi, Pope-Davis, & Dings, 1994; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998, Worthington, Mobley, Franks, & Tan, 2000) have demonstrated its validity and internal consistency by comparing it to Sodowsky et al.'s (1994) original study. I submitted the MCI agreement form by mail to the author and was granted permission to use the 4 subscales of the MCI measure which include multicultural skills, knowledge, awareness, and relationships (see Appendix F).

Sociocultural Attitudes Toward Appearance Scale-3. The original SATAQ was developed to measure a women's appearance based on socially accepted standards and recognition (Heinberg & Thompson, 1995). Thompson et al. (2004) later adapted this measure (SATAQ-3) to examine Western ideals of body image and eating disturbances, and the ways in which the media influences them. The measure was originally designed to address media influence in clients and I modified it for health care professionals to measure participants' perceptions of media influence on AA women's eating disorders. This was a self-reported 30-item questionnaire that consisted of four subscales: Internalization-Athlete, Pressures, Information, and Internalization-General. The Internalization-Athlete subscale consists of 5 questions, such as "I do not wish to look as athletic as the people in magazines". The Pressures subscale consists of 7 questions, including "I've felt pressure from TV and magazines to be thin". The Information

subscale consists of 9 questions, such as "TV programs are an important source of information about fashion and 'being attractive". The Internalization-General subscale consists of 9 items, including "I compare my appearance to the appearance of people in magazines". These subscales were scored on a 5-point Likert scale ranging from 1 (*definitely disagree*) to 5 (*definitely agree*).

Prior to this study, the SATAQ-3 scale had only been used with clients. Thus, I used a modified SATAQ-3 in this study to understand health care professionals' perceptions of media influence when diagnosing eating disorders in AA women. Therefore, this measured was modified by rephrasing the questions from *I* to the *AA client* in order to determine how health care professionals view media's influence on female AA clients. For example, in the Internalization-General subscale, the statement was changed to "AA clients compare their appearance to the appearance of people in magazines". As with the previous version of the measure, the four subscales for this study included Internalization-Athlete, Pressures, Information, and Internalization-General.

The reliability and validity of this adapted measure were assessed through two studies to test for construct validity. The first study consisted of female undergraduate students and used a factor analysis with the following measures: Body Dissatisfaction (EDI-BD), the Ideal Body Internalization Scale-Revised (IBIS-R), Drive for Thinness (EDI-DT), and the Eating Disorder Inventory (Thompson et al., 2004). The Cronbach alphas for each scale were all in the same range as follows: Pressures (.92), Internalization-General (.96), Internalization-Athlete (.95), and Information (.96). In

addition, the scale demonstrated significant correlation with all subscales and the internal consistency for this scale was .95 (Thompson et al., 2004).

In looking at study two which used the adapted version, it also consisted of female undergraduate students and used a factor analysis and computed Cronbach's alpha (Thompson et al., 2004). The measures used in study two consisted of the SATAQ-3, Eating Disorder Inventory-Body Dissatisfaction (EDI-BD) and Eating Disorder Inventory-Drive for Thinness (EDI-DT; Thompson et al., 2004)). The Cronbach's alphas for each scale were as follows: Pressures (.94), Internalization-general (.92), Internalization-athlete (.89), and Information (.94; Thompson et al., 2004)). The convergent correlations were high between the Ideal Body Internalization Scale-Revised (IBIS-R) and Eating Disorder Inventory-Body Dissatisfaction (EDI-BD). Previous research studies that have used this scale and demonstrated the reliability and construct validity included Calogero, Davis, and Thompson, (2004); Forbes, Jobe, and Revak, (2006); Jeffers et al. (2013); and Markland and Oliver (2008). Permission to use this scale was not necessary because the scale is free of cost as long as there is no financial gain. However, I still asked the author for permission to use, modify, and reprint the SATAQ-3, which was granted (see Appendix E).

Data Analysis Plan

Descriptive statistics was used to assess the demographic data of health care professional age, gender, license type, years of clinical experience working with eating disorder clients, and type of work place. To test the hypotheses, inferential statistics were utilized to examine the dependent variable which is health care professionals' perceptions

of media influence on AA clients and the independent variables which are health care professionals' race and cultural awareness. In this section, I discussed the research questions and hypotheses and detail of the data analysis plan. I organized the subsection in the following areas: research questions and hypotheses, and data analysis.

Research Questions and Hypotheses

In this quantitative research study, I addressed the following research questions and hypotheses:

1. Does the race (CA vs. AA) of health care professionals' relate to their perceptions of the extent to which media influences AA women's eating disorders (as measured separately by each of the 4 subscales of the modified SATAQ-3)?

   $H_0$1: Race has no relationship to the health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

   H_a1: Race does have a relationship to the health care professional's perceptions of the extent to which media influences AA women's eating disorders.

2. Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) relate to health care professionals' perceptions of the extent to which media influences AA women's eating disorders (as measured by the modified SATAQ-3)?

   $H_0$2: Cultural awareness has no relationship to health care professionals' perceptions of the extent to which media influences AA women's

eating disorders.

H_a2: Cultural awareness does have a relationship to health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

3. Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) moderate the potential association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders (as measured by the 4 subscales of the modified SATAQ-3)?

   H_03: Cultural awareness does not moderate the association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders.

   H_a3: Cultural awareness does moderate the association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders.

Data Analysis

I answered Research Questions 1 with a Spearman's Rho correlation, Research Question 2 with a Pearson correlation, and Research Question 3 using a hierarchical multiple linear regression analysis in which the dependent (criterion) variable was health care professionals' perceptions of media influence on AA clients and the independent (predictor) variables were health care professionals' race and cultural awareness. First, I examined data to determine if the assumptions of regression analysis were met by testing

for independence, normality, homoscedasticity, and linearity. Homoscedasticity and linearity were detected by examining the scatterplot. To determine independence, I used a Durbin-Watson statistic. To test for normality of residuals, I used a P-P plot.

I conducted a hierarchical multiple linear regression analysis to test Research Question 3. I entered race on Step 1 of this analysis. In Step 1, I entered the four MCI subscale scores after they had been centered around on the mean (i.e., the MCI subscale mean were subtracted from every individual MCI score on that subscale). It is recommended that predictors be centered around their mean when interactions of independent variables are included in a regression analysis (Tabachnick & Fidell, 2013). In step 2, I entered four interaction terms. I computed the interaction terms by multiplying each of the four centered MCI score with the race variable. I entered this interaction term on the second step of the regression analysis. On each step, I examined change in overall R^2 for significance. If a particular step was significant, I examined each of the individual predictors entered on each step for significance. I conducted a regression analysis for each subscale of the modified.

Threats to Validity

In this research study, I explored the threats to validity. Frankfort-Nachmias and Nachmias (2008) reported that external validity refers to the extent by which a study's results can be generalized to other people who have the same characteristics of the participants in the study. First, in regard to external validity, a potential threat included generalizability across populations. The goal was to apply the findings specifically to health care professionals who work with AA eating disorder clients. I reduced this threat

by ensuring a good representation of the sample size that included only AA and CA health care professionals who worked with eating disorder clients. Second, selection bias was another threat to external validity, which was addressed through the use of a purposive sample of 49 health care professionals who met the study's selection criteria. Third, nonresponse bias is also another threat, which could have resulted in a low response rate on the survey and a decrease in the sample size, which could also affect the generalizability of the data. Some surveys could not be used as some participants did not meet the inclusion criteria. Of the 55 individuals who completed the survey questions, the sample size for this study was 49 after excluding individuals who did not meet the inclusion criteria; however, the sample size was still large.

Fourth health care professionals may have tried to guess the study's hypotheses, which could have altered the results of the research study, thereby influencing its validity. Fifth, in regard to internal validity, one potential threat could have been experimental mortality in which participants decide not to complete the study. I addressed this threat by recruiting a large sample size and having only one assessment time point. Sixth, the survey design has many strengths, but also weaknesses. In relation to this study, one of the possible validity threats of the survey design is that surveys are inflexible in many ways (Babbie, 2007). A 4-point and 5-point Likert scale formats were used and participants may be resistant to this format. When filling out the surveys, participants may find some questions ambiguous. Since the survey was conducted through SurveyMonkey, I was not present to provide additional information to participants. However, participants were provided with my contact information on the consent form in

case they had any questions. In addition, the surveys were found to be valid and reliable; therefore, it was assumed that participants understood the questions. Seventh, an internal threat to validity was the modification of the SATAQ-3 and ensuring its reliability and validity. The modification made to the SATAQ-3 were very minor, from using *I* to using *AA client*; therefore, this change was minor which did not affect the survey's validity or reliability.

Ethical Procedures

I conducted the study in accordance with the parameters established by Walden University's IRB to ensure the ethical protection of research participants. Before beginning data collection, I submitted the IRB application to the Walden University IRB and received approval to conduct the study. The participants in this study were health care professionals whom were all licensed and bonded by ethical standards. The participants were provided a copy of the consent form (see Appendix A). The consent form outlined participants' protections and the ethical guidelines I followed during the research study. The consent form included my contact information in case individuals had questions at any time before, during, or after the study. In addition, the consent form included the selection criteria for the study, outlined any physical or psychological risks that the participants might experience, and participants were informed that they were not obligated to complete any parts of the study with which they were not comfortable. In addition, the consent form outlined the anticipated benefits of the study, the lack of compensation, privacy information, disclosure of any potential conflicts of interest, and the contact information of the Walden University representative with whom they could

privately talk about their rights as participants. Participation in the study replied on implicit consent rather than signed consent; therefore, by completing the surveys on SurveyMonkey, their participation in the study was anonymous. All hard copy data are kept in a locked file cabinet in my personal home office. I am the only one with access to this data and the data will be destroyed in 5 years per Walden University guidelines. Electronic data are kept in a password protected computer. I will properly destroy all data after the 5-year time period using methods such as shredding.

Summary

In this study, I examined the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. The research instruments consisted of a researcher-created demographic questionnaire; the SATAQ-3 (Thompson et al., 2004), which I modified; and the MCI (Sodowsky et al., 1994).Using purposive sampling, I collected data from 55 licensed professional counselors, licensed social workers, licensed psychologists, and psychiatrists in the metropolitan Atlanta, Georgia, area. I included data from 49 participants after excluding individuals who did not meet the inclusion criteria. I analyzed data using the SPSS, which included descriptive statistics, Spearman's Rho correlation, Pearson correlation, and a hierarchical multiple linear regression analysis. I invited potential participants to participate in the study and e-mailed a hard copy consent form. I used implied consent and participants completed the surveys on SurveyMonkey; thus, participants' identities were anonymous. I will keep all data secured for at least 5 years.

In Chapter 3, I included the introduction, research design and rationale, methodology, data analysis plan, threats to validity, ethical procedures, and a summary of the chapter. In Chapter 4, I present the introduction, data collection, methodological and statistical assumptions, results, and a summary of the chapter. In Chapter 5, I include the introduction, interpretation of findings, limitations of the study, recommendations, implications, and a conclusion to the study.

Chapter 4: Results

Introduction

The purpose of this quantitative research study was to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. The dependent variable was health care professionals' perceptions of media influence and the independent variables were health care professionals' race and cultural awareness. I examined three research questions. The first research question was whether race (CA vs. AA) of health care professionals' relate to their perceptions of the extent to which media influences AA women's eating disorders (as measured separately by each of the 4 subscales of the modified SATAQ-3). The second research question was whether cultural awareness (as measured separately by each of the 4 subscales of the MCI) relate to health care professionals' perceptions of the extent to which media influences AA women's eating disorders (as measured by the modified SATAQ-3). The third research question was whether cultural awareness (as measured separately by each of the 4 subscales of the MCI) moderate the potential association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders (as measured by the 4 subscales of the modified SATAQ-3). In Chapter 4, I present the data collection, methodological and statistical assumptions, results, and a summary of the chapter.

Data Collection

Data were collected from November 16, 2014 to March 24, 2015. Participants

were recruited from the Georgia Composite Board and License Professional Counseling Association of Georgia which included licensed professional counselors, licensed social workers, licensed psychologists, and licensed psychiatrists in the metropolitan Atlanta, Georgia, area. I recruited participants by e-mail. The participants responded to the study over a 4-month period.

The demographic characteristics assessed in this study included age, gender, race, ethnicity, license type, workplace, years of clinical experience working with persons with eating disorders, and number of eating disorder clients worked with in the past (see Tables 1 and 2). The majority of the participants were female (n = 46). More than half were AA *(*n = 31). Three-fourths (n = 37) of the participants were licensed professional counselors while 53% worked in a private practice. Most participants were in their early twenties (M = 23.3; SD = 9.5.) and had 6 years of clinical experience (SD = 5.6). On average, participants reported having worked with approximately 12 eating disordered clients in the past year (SD = 15.5).

Of the 55 individuals who completed the screening questions, five did not include their age and license type while four individuals did not include gender, race, ethnicity, and years of clinical experience working with eating disorder clients. Six individuals did not include type of work place and two individuals were neither AA nor CA. The sample size for this study was 49 after excluding individuals who did not meet the inclusion criteria.

Table 1

Participants' Gender, Race, License Type, and Type of Workplace (N = 49)

Variable	Frequency	Percentage[a]
Gender		
Male	3	6
Female	46	94
Race		
African American	31	63
Caucasian American	18	37
Not Latino or Hispanic	49	100
Licensed type		
Medical degree	1	2
Licensed professional counselor	37	76
Licensed clinical social worker	10	20
Licensed psychologist	1	2
Licensed marriage/family therapist	0	0
Type of Workplace		
Psychiatric hospital	7	16
Private practice	25	53
Community mental health agency	15	31

Note. [a]Percentage values were rounded.

Table 2

Participants' Age, Years Practicing, and Number of Eating Disorder Clients

Variable	*n*	Minimum Value	Maximum Value	*M*	*SD*
Age	48	23.00	70.00	23.3	9.5
Years practicing	49	1.00	20.00	6.2	5.6
Number of eating disorder clients	46	1.00	50.00	11.8	15.5

Methodological and Statistical Assumptions

I had several assumptions for this research study. I assumed that the instruments used in the study were able to accurately assess the health care professionals' perceptions of media and cultural awareness. The instruments used in the study relied on the health

care professionals to respond to the questions truthfully. Thompson et al. (2004) originally used the SATAQ-3 with clients; however, I modified it so that it could be used with health care professionals. I assumed that the participants in this study honestly provided accurate information based on their knowledge and experience.

In addition to correlational analysis, the statistical analysis included a linear regression analysis in which the dependent (criterion) variable was health care professionals' perceptions of media influence on AA clients and the independent (predictor) variables were health care professionals' race and cultural awareness. Linear regression involves several assumptions that must be met before the analysis is conducted. First, the regression analysis was tested for independence, normality, homoscedasticity, and linearity. The Durbin-Watson test for independence demonstrated no correlation. Homoscedasticity and linearity were detected by looking at the scatterplots. In addition, the normality of residuals was detected by a P-P plot. Therefore, I examined each of these and the assumptions were met.

Results

In examining the reliability analysis in the MCI (Sodowsky et al., 1994), the results from this research studied yielded Cronbach's alphas for each scale, which were as follows: Multicultural Counseling Skills (.70), Multicultural Awareness (.62), Multicultural Counseling Relationships (.65), and Multicultural Counseling Knowledge (.83). In the Multicultural Awareness subscale, the item "I am familiar with nonstandard English" was removed, resulting in a Cronbach's alpha of .67. On the Multicultural Counseling Relationship subscale, the item "I tend to compare clients behaviors with

those of the majority group" was also removed, which increased the Cronbach's alpha to .68. In previous research studies the alpha levels were similar to those found in the current study. In examining the reliability analysis of the modified version of the SATAQ-3 (Thompson et al., 2004) for use with professionals in this research study, the Cronbach's alphas for each scale were as follows: Internalization-General (.91), Internalization-Athlete (.76), Pressures (.88), and Information (.80). Previous research studies reported alpha levels similar to those of the current study. Analysis of the research questions and hypotheses are discussed below. This section is organized in the following subsections: Research Question 1, Research Question 2, and Research Question 3.

Research Question 1

A Spearman's Rho correlation was used to determine if race of health care professionals was associated with health care professionals' perceptions of the extent to which the media influences AA women's eating disorders as measured by the 4 modified SATAQ-3 subscales: Internalization-Athlete, Pressures, Information, and Internalization General. Based on the findings, there was a significant negative correlation between race and the modified SATAQ-3 subscale Pressures, with AA participants perceiving greater eating disorder-related media pressures on AA women than their CA counterparts (see Table 3). Therefore, I rejected the null hypothesis and accepted the alternate hypothesis for one of the SATAQ-3 subscales.

Table 3

Correlations Between Race of Participants and the Subscales on the Modified SATAQ-3

Spearman's Rho	General	Internalization-Athlete	Pressures	Information
Race of participants	-.152	-.194	-.293*	-.215
Row 2				
Row 3				
Row 4				

Note. * $p < .05$

Research Question 2

I used a Pearson correlation to determine if cultural awareness was significantly associated with health care professionals' perceptions of the extent to which media influences AA women's eating disorders. Based on the findings, there was a significant positive correlation between the modified SATAQ-3 subscale Internalization-Athlete (Thompson et al., 2004), and the MCI subscale Awareness (Sodowsky et al., 1994; see table 4). Participants with greater multicultural awareness also had stronger perceptions regarding the influence of athlete-related media on AA women's body image concerns. Therefore, I rejected the null hypothesis and accepted the alternate hypothesis for these particular subscales.

Table 4

Pearson Correlation on the Modified SATAQ-3 Subscales and the MCI Subscales

	Counseling Skills	Knowledge	Relationships	Awareness
General	.025	.237	.010	.179
Athlete	.013	.449	.085	453**
Pressures	-.004	.286	.131	.263
Information	-.119	.278	-.063	.186

Note. ** $p < .01$

Research Question 3

I used a hierarchical multiple linear regression analysis to determine if cultural awareness moderates the potential association between health care professionals' race and their perceptions of the extent to which the media influences AA women's eating disorders. I completed four regression analysis, one for each subscale of the SATAQ-3 as the dependent variable. I entered race in Step 1 of the analysis. Also in Step 1, I entered the MCI subscale scores after they had been centered around their mean (i.e., the MCI mean was subtracted from every individual MCI score). In Step 2, I computed interaction terms by multiplying each of the four centered MCI subscale score and the race variable (Tabachnick & Fidell, 2013). I entered these four interaction terms on the second step of the regression analysis. On each step, I examined change in overall R^2 for significance. None of the second steps on the regression analysis were significant; thus, there were no significant moderation effects for health care professionals' race and their perceptions of the extent to which the media influences AA women's eating disorder (see Tables 5-8). However, as can be seen in Table 8, Step 1 of the regression equation was significant. On this step, the MCI Awareness subscale was a significant predictor of the SATAQ-3 Internalization-Athlete subscale; thus, confirming the positive correlation between these variables noted previously in Research Question 2 analysis.

Table 5

Hierarchical Regression Analysis for Moderating Effects for Subscale Information on the Modified SATAQ-3

Predictor	*B*	*SE*	*T*	*R*	R^2	R^2 Change
Step 1				.426	182	.182
(Constant)	3.807	.107	35.696			
Race of participants	-.058	.104	-.557			
MCI Counseling skills	-.740	.493	-1.449			
MCI Knowledge	.368	.317	1.160			
MCI Awareness	.365	.346	1.054			
MCI Relationship	-.148	.225	-.659			
Step 2				.479	.230	.48
(Constant)	3.78	.129	29.374			
Race of participants	-.060	.129	-.468			
MCI Counseling skills	-.740	.631	-1.172			
MCI Knowledge	.423	.349	1.213			
MCI Awareness	.151	.414	.365			
MCI Relationship	-.002	.300	-.006			
Race × Counseling skills	-.200	.631	-.317			
Race × Knowledge	.234	.349	.670			
Race × Awareness	-.379	.414	-.915			
Race ×Relationship	.053	.300	.177			

Table 6

Hierarchical Regression Analysis for Moderating Effects for Subscale Pressures on the Modified SATAQ-3

Predictor	*B*	*SE*	*T*	*R*	R^2	R^2 Change
Step 1				.373	.139	.139
(Constant)	3.844	.136	28.195			
Race of participants	-.058	.133	-.438			
MCI Counseling skills	-.589	.631	-.934			
MCI Knowledge	.402	.406	.991			
MCI Awareness	.375	.443	.849			
MCI Relationship	.057	.287	.197			
Step 2				.446	.199	.060
(Constant)	3.776	.164	23.055			
Race of participants	-.164	.164	-.999			
MCI Counseling skills	-.390	.802	-.486			
MCI Knowledge	.381	.443	.859			
MCI Awareness	.227	.526	.431			
MCI Relationship	-.064	.381	-.168			
Race × Counseling skills	.831	.802	1.035			
Race × Knowledge	.086	.443	.193			
Race × Awareness	-.537	.526	-1.021			
Race ×Relationship	-.011	.381	-.028			

Table 7

Hierarchical Regression Analysis for Moderating Effects for Subscale Internalization-General on the Modified SATAQ-3

Predictor	*B*	*SE*	*T*	*R*	R^2	R^2 Change
Step 1				.271	.074	.074
(Constant)	3.843	.136	28.270			
Race of participants	-.028	.133	-.211			
MCI Counseling skills	-.302	.629	-.480			
MCI Knowledge	.355	.404	.878			
MCI Awareness	.250	.441	.567			
MCI Relationship	.075	.286	-.263			
Step 2				.408	.167	.093
(Constant)	3.769	.161	23.478			
Race of participants	-.133	.161	-.827			
MCI Counseling skills	-.214	.786	-.273			
MCI Knowledge	.309	.434	.710			
MCI Awareness	-.025	.516	-.048			
MCI Relationship	-.107	.373	-.287			
Race × Counseling skills	.694	.786	.882			
Race × Knowledge	-.079	.434	-.181			
Race × Awareness	-.701	.516	-1.359			
Race ×Relationship	.135	.373	.362			

Table 8

Hierarchical Regression Analysis for Moderating Effects for Subscale Internalization-Athlete on the Modified SATAQ-3

Predictor	*B*	*SE*	*T*	*R*	R^2	R^2 Change
Step 1				.592	.351	.351*
(Constant)	3.433	.121	28.414			
Race of participants	-.019	.118	-.165			
MCI Counseling skills	-.853	.559	-1.526			
MCI Knowledge	.556	.359	1.546			
MCI Awareness	.913	.392	2.328*			
MCI Relationship	-.222	.254	-.874			
Step 2				.631	.398	.770
(Constant)	3.340	.145	23.060			
Race of participants	-.095	.145	-.657			
MCI Counseling skills	-.459	.710	-.647			
MCI Knowledge	.490	.392	1.250			
MCI Awareness	.743	.466	1.596			
MCI Relationship	-.264	.337	-.783			
Race × Counseling skills	.478	.710	.674			
Race × Knowledge	-.035	.392	-.090			
Race × Awareness	-.346	.466	-.744			
Race ×Relationship	-.207	.337	-.615			

Note. * p <.05

Summary

I conducted a statistical analysis in order to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women. I tested the statistical assumptions, which were met. For Research Question 1, the statistical analysis performed supported the hypothesis that health care professionals' race is partially related to their perceptions of the extent to which the media influences AA women's eating disorders based on a negative correlation between race and the modified SATAQ-3 subscale Pressures (Thompson et al., 2004).

Therefore, I rejected the null hypothesis and accepted the alternate hypothesis for one of the SATAQ-3 subscales. For Research Question 2, the correlational analysis performed with the modified SATAQ-3 and the MCI revealed a positive correlation between the MCI subscale Awareness and the Internalization-Athlete subscale on the modified SATAQ-3, which provides partial support for Research Question 2. Therefore, I rejected the null hypothesis and accepted the alternate hypothesis for these particular subscales.

For Research Question 3, there were no significant moderation effects for health care professionals' race and their perceptions of the extent to which the media influences AA women's eating disorder; however, Step 1 of the regression equation was significant. On this step, the MCI Awareness subscale was a significant predictor of the SATAQ-3 Internalization-Athlete subscale; thus, confirming the positive correlation between these variables noted previously in Research Question 2 analysis. In Chapter 4, I presented the introduction, data collection, methodological and statistical assumptions, results, and a summary of the chapter. In Chapter 5, I include the introduction, interpretation of findings, limitations of the study, recommendations, implications, and a conclusion to the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this quantitative research study, I examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women. An online survey was administered to a diverse array of health care professionals including licensed professional counselors, social workers, psychologists, and psychiatrists. Participants practiced in the metropolitan Atlanta, Georgia, area and had experience working with women with eating disorders. The survey instruments included a researcher-created demographic questionnaire, the MCI (Sodowsky et al., 1994), and a modified SATAQ-3 (Thompson et al., 2004). I collected data anonymously through the SurveyMonkey website and I analyzed data using the SPSS.

For Research Question 1, findings supported the hypothesis that health care professionals' race is partially related to their perceptions of the extent to which the media influences AA women's eating disorders based on a negative correlation between race and the modified SATAQ-3 subscale Pressures (Thompson et al., 2004). For Research Question 2, findings indicated a positive correlation between the MCI subscale Awareness and the Internalization-Athlete subscale on the modified SATAQ-3. For Research Question 3, there were no significant moderation effects for health care professionals' race and their perceptions of the extent to which the media influences AA women's eating disorder; however, Step 1 of the regression equation was significant. On this step, the MCI Awareness subscale was a significant predictor of the SATAQ-3

Internalization-Athlete subscale. In Chapter 5, I discussed the interpretation of findings, limitations of the study, recommendations, implications, and a conclusion to the study.

Interpretation of the Findings

In an effort to determine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorder-related factors in AA women, I examined three research questions. In working with AA women clients who are seeking treatment for eating disorders, health care professionals should consider the race of their clients (Fernandes et al., 2010) and use racially specific measures when assessing their specific body image concerns (Baugh et al., 2010). The majority of research on eating disorders have focused on CA females, which may lead to heath care professional biases due to the assumption that eating disorders occur mostly in CA women (O' Neil, 2003). Hence, health care professionals' biases may result in health issues for minority groups who suffer from eating disorders. The finding are interpreted in the context of the theoretical foundation and the literature review. This section is organized in the following subsections: Research Question 1, Research Question 2, and Research Question 3.

Research Question 1

Does the race (CA vs. AA) of health care professionals' relate to their perceptions of the extent to which media influences AA women's eating disorders (as measured separately by each of the 4 subscales of the modified SATAQ-3)? Findings only partially supported an association between health care professionals' race and their perception of media influence on factors relating to eating disorders in AA women. I found a significant

negative correlation between race and the Pressures subscale of the SATAQ-3 (Thompson et al., 2004); however, I did not find any other significant associations. AA health care professionals perceived greater media related pressure on AA women to maintain a particular body type than did CA health care professionals. The Pressures subscale of the modified SATAQ-3 (Thompson et al., 2004) measured pressures from television and magazines to look pretty, be thin, have a perfect body, diet, and exercise.

The theories presented in Chapter 2 may explain why there was a negative correlation found for this particular subscale. The main focus of SCT is to understand how humans compare themselves to others and make changes to their environment (Festinger, 1954). Perhaps health care professionals who are AA perceive more pressure than CA professionals based on their own as well as others' experiences with such pressures. Additionally, according to Bandura (1977), in SLT, people learn behaviors through modeling. Perhaps CA health care professionals may perceive that pressures to be thin are more common in CA women than AA women based on media influences that primarily depict thin CA women on televison and in magazines (Chao et al., 2008). Based on the findings for Research Question 1, I rejected the null hypothesis for one subscale; race does have a relationship, although limited, to health care professionals' perceptions of the extent to which media influences AA women's eating disorders.

Specifically, I found no other significant associations of race with the other SATAQ-3 subscales (Thompson et al., 2004) regarding the perceptions of media influence on eating disorder-related factors in AA women. These subscales included Internalization-General, which researchers used to measure women's body image on

television and magazines; Internalization-Athlete, which measures body image as it relates to athletics, being in good shape, and famous sport stars; and Information, which measures being attractive based on magazine articles, magazine advertisement, magazine pictures, television programs, movies, and music videos (Thompson et al., 2004). Health care professionals' race simply may not be influential in their assessments of these three particular factors related to AA women's eating disorders, suggesting that it is less critical for these professionals to understand their own biases and stereotypes about other cultures and races (Sue et al., 1992). However, I found racial differences in participants' perceptions of media pressure on eating disorder-related factors in AA women, which suggested that consideration of health care professional race is important for this particular component of media influence.

Research Question 2

Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) relate to health care professionals' perceptions of the extent to which media influences AA women's eating disorders (as measured by the modified SATAQ-3)? Although most of the associations between the cultural awareness subscales and the dependent measures were not significant, I found a positive correlation between the MCI cultural Awareness subscale (Sodowsky et al., 1994) and the Internalization-Athlete subscale (Thompson et al., 2004). Participants with greater multicultural awareness also reported stronger perceptions of the role of athlete-related media on AA women's body image. Thus, the alternative hypothesis for Research Question 2 was partially supported; hence, cultural awareness does have a limited relationship to health care professionals'

perceptions of the extent to which the media influences eating disorder-related factors for AA women.

Findings from SLT research suggested that media can have social influences on body image, which may lead to disordered eating behaviors (Harrison & Cantor, 1997; Starr & Ferguson 2012; Stice et al., 1994). In addition, CA women tend to be thinner in magazines than AA women (Moriarty & Harrison, 2008). Hence, this study investigated whether cultural awareness is related to health care professionals' perceptions of the extent to which the media influences AA women's eating disorder-related factors. Cultural awareness was significantly positively associated with health care professionals' perceptions of the extent to which media influence AA women's desire to look like athletes depicted in the media. Perhaps health care professionals who are more culturally aware have greater exposure to social influences such as the depiction of AA female athletes in the media and thus more strongly perceive that AA women feel pressured to look like athletes than do participants with less cultural awareness.

Furthermore, to understand Research Question 2 findings, the TIM model was used as a foundation for this research study to examine whether or not health care professional's cultural awareness is related to their perception of eating disorders based on media influence in AA women. This model consisted of the integrative model, social constructivist's model, collaborative model, and multicultural theory (Garcia et al., 2003). This theory was developed to examine cultural factors when making ethical decision making (Garcia et al., 2003). The model has four steps, which include (a) fact finding and awareness; (b) collecting cultural information from the client, consulting with

colleagues on multiculturalism, and reviewing code of ethics; (c) understanding opposing nonmoral values that may interfere with treatment; and (d) taking the appropriate course of action for treatment. The purpose of this model is to assist health care professionals in making appropriate ethical decisions when cultural barriers can cause an obstacle for treatment. Perhaps health care professionals did apply at least some of the steps listed above to understand how AA women internalize body image of an athlete through media influences and did take into account the cultural factors as mention previously. Therefore, based on these findings and applied theories, the findings suggested that cultural awareness is related to health care professionals' perceptions of the extent to which athlete-related media influences on eating disorder-related factors in AA women.

Research Question 3

Does cultural awareness (as measured separately by each of the 4 subscales of the MCI) moderate the potential association between health care professionals' race and their perceptions of the extent to which media influences AA women's eating disorders (as measured by the 4 subscales of the modified SATAQ-3)? Findings indicated that there was only one significant association between race and the dependent variables, and that incorporating cultural awareness had no influence; hence, no moderation effect was found. It appeared that the relationship between health care professionals' race and their perceptions of media influence on AA women's body image was limited to one aspect of perceptions and was not influenced by cultural awareness. Hence, there were no significant moderation effects for health care professionals' race and their perceptions of the extent to which the media influences AA women's eating disorder; however, Step 1 of

the regression equation was significant. On this step, the MCI Awareness subscale was a significant predictor of the SATAQ-3 Internalization-Athlete subscale. thus, confirming the positive correlation between these variables noted previously in Research Question 2 analysis.

Limitations of the Study

This study had several limitations which included self-report data, self-selection bias, and research design. Self-reported data was a limitation to this study because some of the participants did not complete all of the answers in the survey. It was assumed that each participant would have read and completed each question in the survey as instructed. However, participants may not have allotted enough time to complete the survey or they may have felt uncomfortable completing some of the items. The survey was anonymous in order to mitigate self-report concerns and encourage the participants to respond honestly. Self-selection biases may also have been a limitation of this study. I modified the SATAQ-3 in order to use it with health care professionals rather than clients. Even though the modifications were minor, additional research could be done to further validate this modification. *Type I error* may have also been inflated due to the number of statistical tests conducted. Finally, this research design relied on correlational data; thus, casual relationships between the variables could not be established.

Recommendations

This research study was the first study to examine health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women. I collected data through the use of a researcher-created demographic questionnaire, the

MCI (Sodowski et al., 1994), and a modified SATAQ-3 (Thompson et al., 2004). I made several recommendations based on the results of this study.

First, findings demonstrated that AA health care professionals rate the media pressures on AA women to maintain a particular body type as higher than CA health care professionals. O'Neill (2003) found that health care professionals may misdiagnose eating disorders in AA women due to the perception that CA women mainly have eating disorders. In addition, Bowen and Schmid (1997) reported that the majority of media images depict CA women and this may reinforce health care professionals' misperceptions. Therefore, health care professionals' race differences needed to be considered when AA clients sought eating disorders treatment (Fernandes, et al., 2010), as well as the consideration of specific cultural barriers when assessing body image of AA women (Baugh et al., 2010). Based on these findings, I recommend that health care professionals receive additional educational training on how pressures from the media may influence eating disorders in AA women compared to CA women as additional education will help to increase their awareness, early detection, diagnosis, and treatment of eating disorders among AA women, which helps AA women receive the care that they need.

In this study, I found that cultural awareness had a limited relationship with health care professionals' perceptions of the extent to which the media influences AA women's eating disorders. Thus, it would be helpful for health care professionals to have a better understanding on AA women and eating disorders by understanding how AA women view athletics and body image. Since athletics can shape body image in a positive or

negative way, it may be useful for health care professionals to explore the influence of athleticism when working with women with eating disorders or body image concerns. Reiter and Graves (2010) suggested that having knowledge on ideals of beauty, negative body image, eating habits, psychological factors, physical activities, social pressure from athletics, school or work, and cultural factors can assist in the treatment of eating disorders.

I also recommend that this study be replicated to confirm or disconfirm these findings. Additionally, a larger sample size or more diverse sample could be utilized. Perhaps a study that focused on AA women and the role of athleticism in body image and eating disorders may provide further insight into this study's findings. Furthermore, a study that focuses on understanding how health care professionals examine pressures from the media that may influence AA women eating disorder behaviors may also provide useful information to include in training health care professionals on these issues. Furthermore, the action for dissemination of these findings can be done through a peer-reviewed journal as well as presenting these findings to health care professionals at conferences. Since this is the first study to examine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women, additional research possibilities exists.

Health care professionals need take into account customs, social behavior, and religion when seeking to diagnose eating disorders in AA women (Kelly et al., 2011). Therefore, it is important to understand the role of cultural influences on AA culture, which includes slavery and postreconstruction (Malson et al., 1990) and socioeconomic

status, acculturation, and racial identity as it relates to AA women and eating disorders (Talleyrand, 2010). Other factors include sexism and classism as AA women seek employment (Greene, 1994). This may lead AA women to change their cultural standards to those of their CA counterparts (Root, 1990). Thus, it is important to further understand how pressures from society, racial biases, and discrimination may lead to the development of eating disorders in AA women (Talleyrand, 2006).

Implications

Findings from this study may be used to effect positive social change for health care professionals. In this study, I focused on the etiology of eating disorders, understanding eating disorders in AA women, cultural as well as media influences in AA women, and health care professionals' race and cultural awareness as it relates to eating disorders in AA women. Findings from this research study may be used to help AA women who may have been overlooked for an eating disorder based on the health care professional's perceptions of eating disorders in AA women. Findings indicated that cultural awareness has a very specific relationship to health care professionals' perceptions of the extent to which the media influences AA women's eating disorders. In addition, findings indicated that health care professionals' race does have a limited relationship to their perceptions of the extent to which media pressures influence AA women's eating disorders. Thus, health care professionals may need additional training on AA women's culture and how cultural awareness may influence their perception of eating disorders in AA women.

Research findings suggested that health care professionals may need to develop a

better understanding on how AA women view athletics and body image in order to understand how this may be associated with disordered eating behaviors in AA women. Findings indicated that health care professionals may also need additional education on how pressures from the media may influence eating disorder behaviors in AA women. Furthermore, findings from this research study may lead to future research studies on AA women with eating disorders because the majority of previous research studies on eating disorders have been done on CA women (O'Neill, 2003), and there is a lack of data on how many AA women have eating disorders and reported new cases (Mulholland & Mintz, 2001). Thus, the results of this study indicated that further exploration of health care professionals' cultural awareness is needed in order to better understand how these variables may impact eating disorder diagnosis and treatment in AA women.

Conclusion

The aim of this study was to determine the associations among health care professionals' race, cultural awareness, and perceptions of media influence on eating disorders in AA women. This was the first research study to examine these associations. Health care professionals' race was slightly related to their perceptions of health care professionals' perceptions of the extent to which the media influences AA women's eating disorders. Cultural awareness had a limited relationship with health care professionals' perceptions of the extent to which the media influences AA women's eating disorders, which indicated that it is important for health care professionals to take into account their own level of cultural awareness when diagnosing and treating AA women (Garcia et al., 2003). Findings from this study provided new information

regarding the important role of cultural awareness when health care professionals are assessing eating disorders in AA women. In conclusion, findings from this research study fits into Walden University's social change mission by demonstrating the need for health care professionals to be more aware of cultural barriers when working with AA women clients who may be suffering from an eating disorder.

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Appendix A: Participant Consent Form

You have been invited to participate in a research study to explore health care professionals' perceptions of media influence on eating disorders in African American women. You were selected as a potential participant because you have been identified as a licensed health care professional through the State of Georgia Licensing Board or the Licensing Professional Counseling Association Board of Georgia. Please read the following consent form and please contact me directly regarding any questions that you may have regarding this research study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. This study is being conducted by a researcher named Erica Hudson who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to gain an understanding of health care professionals' perceptions of media influence on eating disorders in AA women.

Procedures:

- The research study will be completed by following the link provided to access the SurveyMonkey website.
- Complete a demographic questionnaire and 2 surveys on the SurveyMonkey website.
- The expected time to complete the demographic questionnaire and 2 surveys will take approximately 15-20 minutes. The materials will be available for 30 days on

SurveyMonkey. By, completing the surveys and demographic questionnaire will demonstrate your consent to participate in the research study.

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Georgia Licensing Board or Licensing Professional Counseling Association Board of Georgia will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Being in the Study:

There are no risks associated for your participating in this research study. However, there are potential benefits for social change through your participation in this research study. If, the hypotheses are supported, findings may suggest that health care professionals may need additional training on eating disorders in African American women.

Payment:

There will be no compensation provided for your participation in this research study.

Confidentiality:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by hard copy and locked in a secure file drawer to keep the data confidential. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher Erica Hudson to answer any questions regarding this research study via [redacted] or [redacted]. If, you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is [redacted]. Walden University's approval number for this study is 10-21-14-0042289, and it expires on 10/20/15. Please retain this information for your personal records.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By clicking the link below "I consent", I understand that I am agreeing to the terms described above.

Appendix B: Permission to Conduct Research Using SurveyMonkey

SurveyMonkey Inc.
www.surveymonkey.com

For questions, visit our Help Center
help.surveymonkey.com

Re: Permission to Conduct Research Using SurveyMonkey

To whom it may concern:

This letter is being produced in response to a request by a student at your institution who wishes to conduct a survey using SurveyMonkey in order to support their research. The student has indicated that they require a letter from SurveyMonkey granting them permission to do this. Please accept this letter as evidence of such permission. Students are permitted to conduct research via the SurveyMonkey platform provided that they abide by our Terms of Use, a copy of which is available on our website.

SurveyMonkey is a self-serve survey platform on which our users can, by themselves, create, deploy and analyze surveys through an online interface. We have users in many different industries who use surveys for many different purposes. One of our most common use cases is students and other types of researchers using our online tools to conduct academic research.

If you have any questions about this letter, please contact us through our Help Center at help.surveymonkey.com.

Sincerely,

SurveyMonkey Inc.

Appendix C: Demographic Questionnaire

Instructions: Please respond to each item below.

1. *Please enter your age in the text box: _____*
2. *Please enter your gender in the text box: _____*
3. *Please indicate your race (check all that apply):*

___White Persons (Caucasians, non-Hispanics)

___Black Persons (African American, Afro-Caribbean/West Indies Americans)

___American Indian and Alaska Native Persons

___Asian Persons

___Hispanic Persons

___Other Pacific Islander Persons (Chamorro, Native Hawaiians, Samoan Americans)

___Other (Please specify)

4. *Please indicate your license type:*

___ Medical Degree

___ Licensed Professional Counselor

___ Licensed Clinical Social Worker

___ Licensed Psychologist

___ Licensed Marriage and Family Therapist

5. Please indicate your type of work place:

___ Psychiatric Hospital

___ Private Practice

___ Community Mental Health Agency

6. *How many years of clinical experience working with persons with eating disorders?____*

Appendix D: Modified Sociocultural Attitudes Toward Appearance Scale-3

(Thompson et al., 2004)

Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

Internalization- General: Items: 3, 4, 7, 8, 11, 12, 14, 16, 27
Internalization- Athlete: Items: 19, 20, 23, 24, 30
Pressures: Items: 2, 6, 10, 14, 18, 22, 26
Information: Items: 1, 5, 9, 13, 17, 21, 25, 28, 29

Definitely Disagree = 1
Mostly Disagree = 2
Neither Agree or Neither Disagree = 3
Mostly Agree =4
Definitely Agree = 5

1. TV programs are an important source of information about fashion and "being attractive." _____
2. African American women feel pressure from TV or magazines to lose weight. _____
3. African American women do not care if there body looks like the body of people who are on TV. _____
4. African American women compare their body to the bodies of people who are on TV. _____
5. TV commercials are an important source of information about fashion and "being attractive." _____
6. African American women do not feel pressure from TV or magazines to look pretty. _____
7. African American women would like their body to look like the models who appear in magazines. _____

8. African American women compare their appearance to the appearance of TV and movie stars. _____
9. Music videos on TV are not an important source of information about fashion and "being attractive." _____
10. African American women feel pressure from TV and magazines to be thin. _____
11. African American women would like their body to look like the people who are in movies. _____
12. African American women do not compare their body to the bodies of people who appear in magazines. _____
13. Magazine articles are not an important source of information about fashion and "being attractive." _____
14. African American women feel pressure from TV or magazines to have a perfect body. _____
15. African American women wish they looked like the models in music videos. _____
16. African American women compare their appearance to the appearance of people in magazines. _____
17. Magazine advertisements are an important source of information about fashion and "being attractive." _____
18. African American women feel pressure from TV or magazines to diet. _____
19. African American women do not wish to look as athletic as the people in magazines. _____

20. African American women compare their body to that of people in "good shape." _____
21. Pictures in magazines are an important source of information about fashion and "being attractive." _____
22. African American women feel pressure from TV or magazines to exercise. _____
23. African American women wish they looked as athletic as sports stars. _____
24. African American women compare their body to that of people who are athletic. _____
25. Movies are an important source of information about fashion and "being attractive." _____
26. African American women feel pressure from TV or magazines to change their appearance. _____
27. African American women do not try to look like the people on TV. _____
28. Movie starts are not an important source of information about fashion and "being attractive." _____
29. Famous people are an important source of information about fashion and "being attractive." _____
30. African American women try to look like sports athletes. _____

Appendix E: Permission to Use, Modify, and Reprint the Sociocultural Attitudes Toward Appearance Scale-3 (Thompson et al., 2004)

On Thursday, September 25, 2014 11:55 AM, "Thompson, J. Kevin" <redacted> wrote:

Sure, also see attached, our new version if you would like to use it instead, in press at Psychological Assessment.

From: Erica Handy <redacted>
Sent: Tuesday, September 23, 2014 10:19 PM
To: Thompson, J. Kevin
Subject: Dissertation- Request to use the SATAQ-3

Dear Dr. Thompson,

I am Erica Hudson a doctoral student at Walden University. I am currently working on my dissertation and would like to request your permission to use The Sociocultural Attitudes Towards Appearance Questionnaire 3 (SATAQ-3) in my research study. This measure will be used for graduate school purposes only and there will be no monetary gain.

Thank You,

Erica Hudson

Appendix F: Permission to Use the Multicultural Counseling Inventory

(Sodowsky et al., 1994)

On Thursday, September 11, 2014 8:32 AM, Catherine G. Peterson <redacted> wrote:

Greetings, Erica.

Thank you for your payment of $100 for the procedural use of the MCI.

Attached is the measure and related readings that Gargi sends.

Please confirm that you've received and can open the attached documents.

Best regards,

Catherine

Catherine G. Peterson
Administrative Director
Department of Clinical Psychology
Doctoral Program in Clinical Psychology
****
Antioch University New England
40 Avon Street
Keene, New Hampshire 03431
direct line: [redacted]
fax number: [redacted]

Appendix G: NIH Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Erica Hudson** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 08/17/2014.

Certification Number: 1509010.