INITIAL TESTING OF THE RISK ASSESSMENT OF EATING DISORDERS (RAED) TOOL FOR USE IN PRIMARY CARE OF HISPANIC WOMEN

by

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A DNP Project Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF NURSING PRACTICE

In the Graduate College

THE UNIVERSITY OF ARIZONA

2016
THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

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ACKNOWLEDGMENTS

This Doctor of Nursing Practice project was led by the expect guidance of Dr. Pamela Reed, who without her help, patience, and knowledge, this project would yet to be completed.

I would also like to thank the remainder of my committee members: Dr. Kate Sheppard and Dr. Janet DuBois for their willingness to be part of this project, in addition to sharing their time, patience and expertise.

Lastly, I would like to acknowledge Dr. Brenda Wolfe who inspired me to work with the population of interest- Hispanic women with eating disorders. Thank you for sharing your knowledge, facility and resources.
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ABSTRACT

Purpose of the Study: The purpose of this study was to test an investigator-developed culturally relevant eating disorder assessment tool, the Risk Assessment of Eating Disorders (RAED), for eventual clinical application in assessing eating disorders in Hispanic women. This study also examined clinical guidelines, developed by the investigator to guide providers in using culturally appropriate behaviors during the assessment process.

Research Questions: 1. What do Hispanic women identify and endorse as relevant areas of assessment for detection of potential eating disorders? 2. What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders? 

Background: Although some knowledge exists regarding appropriate and effective assessment questions to detect eating disorders, clinicians lack a culturally relevant and brief tool for use in primary care. Literature on existing assessment instruments and the Theory of Cultural Marginality informed development of the tool and guidelines.

Method: Five Hispanic females with diagnosed eating disorders completed the RAED tool and scored items for relevance and clarity. This was followed by interviews and discussions with participants concerning perceptions of provider behaviors that enable or inhibit women reporting specific disordered eating behaviors to providers.

Results: The results supported relevance and clarity of a 14-item RAED for assessing eating disorders. Seven clinical guidelines were developed on culturally appropriate provider behaviors to help Hispanic women volunteer specific information on their eating disorder behaviors.
Discussion: A shorter assessment was developed for eventual use in advance practice nursing. The participants also identified provider behaviors including empathy, a non-judgmental attitude, and being willing to sit down with the patients, as enabling them to speak up about their eating disorder. The Theory of Cultural Marginality was useful in developing the RAED items and Provider Guidelines for assessment. Continued research of the RAED and clinical guidelines was recommended to provide adequate empirical support for use of the assessment tools and theory by advance practice nurses in primary care of Hispanic women, as well as all women with eating disorders.
STATEMENT OF THE PROBLEM

Introduction

According to the National Eating Disorder Association (“Get the Facts,” 2013), 20 million women in the United States (U.S.) have experienced a clinically significant eating disorder at some point in their lives. Epidemiological studies suggest the following lifetime prevalence of each eating disorder: anorexia nervosa 0.5 to 3.7%, bulimia nervosa 1.5 to 2.8%, binge eating disorder 3.5%, and eating disorders not otherwise specified 1 to 14% (Garzon & Figgemeier, 2011; Smink, Van Hoeken, & Hoek, 2012). Contrary to popular opinion, studies have documented the fact that eating disorders appear to be as prevalent among ethnic minority groups as among whites, although minorities do not seek treatment as readily (Markey Hood, Vander Wal, & Gibbons, 2009; Gordon, Perez, & Joiner, 2002; Cachelin, Striegel-Moore, & Regan, 2006).

Consequences of eating disorders are visible at both monetary and physical levels. For example, in 2005-2006, more than $271 million was spent for hospitalizations and direct expenses to treat the eating disorders of more than 28,000 people (Garzon & Figgemeier, 2011). Pertaining to physical consequences, eating disorder behavior may result in injury to organ systems, as well as mortality. Specifically, anorexia has the highest mortality rate of all psychiatric illnesses (Smink et al., 2012). Expenditures for Hispanic women to seek treatment may be less than posted figures because of ethnic barriers to seek treatment (Cachelin & Striegel-Moore, 2006). This condition is much more than an eating disorder; it is a sequela with significant financial burdens.
It is proposed that in 50 years the U.S. minority population is expected to approach 50% of the total number of inhabitants (Becker, Franko, Speck, & Herzog, 2003). The resulting gaps in health disparities among these individuals will be even more problematic as a result of this growth. This amounts to a staggering number of Americans subject to the ravages of eating disorders—the negative impact of which has been likened to that of chronic schizophrenia or bipolar disorder (Carter, Bewell, & Devins, 2008).

Primary care providers, including advanced practice nurses, are often the first line resources in assessing, detecting, and intervening with eating disorders, specifically among ethnic minority women. However, most health-care providers lack adequate training to recognize subclinical or clinical eating disorders (Linville, Benton, O’Neil, & Sturm, 2010). Advanced practice nurses are willing do engage in patient screening for eating disorders, however they feel that treating individuals with eating disorders is complex and out of their depth of practice (Duffin, 2013). Moreover, the common misperception that ethnicity somehow protects women from eating disorders means that this front-line resource is not as effective as it could and should be. The long-term goal of the proposed research was to generate knowledge and better assessment approaches that enable providers to ask the right questions to assess potential eating disorders and overcome cultural barriers in identifying eating disorders in Hispanic women.

**Purpose of Study**

Some knowledge exists regarding potentially appropriate and effective assessment questions to detect eating disorders. However, research has not specifically addressed questions from the perspectives of Hispanic women. While the extant literature provides a beginning framework, the next critical step to is to obtain the empirical data needed to develop and refine
an assessment framework that explicitly addresses the needs of these women. Ultimately, this protocol could be used by healthcare providers to assess and treat Hispanic women with eating disorders. Thus, the purpose of this study was to conduct initial research in testing an investigator-developed culturally relevant eating disorder assessment tool for clinical application, based on perspectives of Hispanic women who were diagnosed with an eating disorder and agreed to participate in the study. A second purpose was to obtain information from these women regarding provider behaviors that may foster culturally sensitive interactions with Hispanic patients.

**Background and Significance**

Rates at which specific eating disorders occur varies among ethnic groups, however some studies suggest that overall, there is no difference in prevalence (Alegria, Woo, Cao, Torres, & Striegel-Moore, 2007; Marques, Alegria, Becker, Chen, Fang, Chosak, & Diniz, 2011). Collected data from the NIMH Collaborative Psychiatric Epidemiological Studies confirmed variability in prevalence of eating disorders among ethnic groups, with higher 12-month and lifetime rates for Latinos with bulimia nervosa and any binge eating compared to other ethnicities (Marques et al., 2011). Lifetime prevalence rates for Latino individuals with bulimia were 2.03% versus 1.31% and .51% for African Americans and non-Latino Whites, respectively, and 5.6% for Latinos with any binge eating compared to 4.83% for African Americans, 4.74% for Asians, and 2.53% non-Latino Whites, respectively (Marques et al., 2011). Conversely, one study stated prevalence rates for Latinos with anorexia nervosa were lowest when compared to other ethnicities, while a different study suggested prevalence rates for anorexia and binge eating disorder were similar across ethnicities (Alegria et al., 2007; Smink et al., 2012).
Eating disorder behavior and prevalence is the result of multiple influences including genetic, biological, and socio-environmental factors. In regards to genetics, studies suggest behavioral traits such as perfectionism, rigidity, and disinhibition are largely influenced by genes, thus resulting in 22 to 76% of anorexia and 53 to 83% of bulimia cases (Garzon & Figgemeier, 2011).

**Genetic Studies**

Genetic studies specific to anorexia have demonstrated the presence of variants in the Estrogen Receptor Beta (ESR2) gene, thus confirming previous hypotheses on the mediating effects of estrogen and estrogen receptors in anorexia (Scott-Van Zeeland et al., 2013; Trace, Baker, Penas-Lledo, 2013). Additional variants were discovered in the Epoxide Hydrolase 2 (EPHX2) gene demonstrating alterations in carbohydrate metabolism (Scott-Van Zeeland et al., 2013). Presence of each risk allele corroborates data indicating women are more likely to suffer from anorexia compared to men and have high serum cholesterol levels in conjunction with this diagnosis (Trace et al., 2013; Scott-Van Zeeland et al., 2013).

Studies on genetics and bulimia have suggested significant associations with the risk for obesity A allele and bulimia in examining the role of the common FTO gene SNP rs9939609 (Trace, Baker, Penas-Lledo, & Bulik, 2013). Moreover, studies showed a significant association with the 171T/C polymorphism and the growth hormone secretagogue receptor (GHSR) gene, thus implicating abnormal appetite regulation in patients with bulimia (Trace et al., 2013).

**Biological Factors**

Biological factors including serotonin, dopamine, and leptin are thought to contribute to eating disorder behaviors by creating vulnerability through altered chemical levels (Garzon &
Figgemeier, 2011). Specifically, altered levels of serotonin and dopamine have been found in the cerebral spinal fluid of patients with anorexia and bulimia (Garzon & Figgemeier, 2011). The low levels in individuals with bulimia prevent satiety, while high levels in patients with anorexia produce abnormal sensations of fullness (Garzon & Figgemeier, 2011). Leptin is another biologic factor that appears altered in eating disorders and prevents the normal somatic response of signaling the body to increase or decrease intake (Garzon & Figgemeier, 2011). Therefore, the response of leptin to hunger, energy, homeostasis, and satiety is altered, and high levels of leptin are present with weight loss and decreased in individuals with weight gain (Garzon & Figgemeier, 2011). Notwithstanding, the effects of leptin on metabolism in the hypothalamic pituitary axis may prevent individuals with eating disorders to regain weight effectively (Garzon & Figgemeier, 2011).

**Socio-environmental Factors**

Socio-environmental factors influencing eating disorder risk include sports involvement, chronic illnesses, sexuality, beliefs about the importance of controlling weight and size, and stressful life events. Specifically, sports focusing on body type and weight are more likely to result in athletes meeting criteria for subthreshold or full eating disorder diagnosis (Garzon & Figgemeier, 2011). Examples of these sports include wrestling, dance, cheerleading, gymnastics, and cross-country running (Garzon & Figgemeier, 2011). In regards to chronic illnesses, individuals with diabetes and cystic fibrosis are more likely to develop eating disorders from strict dietary regulations (Garzon & Figgemeier, 2011). Moreover, obese individuals are more likely to engage in eating disorder behaviors and suffer from body dysmorphism after losing large amounts of weight (Garzon & Figgemeier, 2011).
Data pertaining to sexuality suggests homosexual males are more likely to develop an eating disorder, while homosexual women are least likely to experience this illness (Garzon & Figgemeier, 2011). Eating disorder prevalence is also affected by sociocultural pressures to be thin and the resultant belief that it is important (to beauty, to success, and to love) that the individual be able to control his/her body weight and shape. Given that body size/shape is considerably less controllable than popular opinion holds, this belief leads to body dissatisfaction, preoccupations with dieting and body shape, and hence vulnerability to developing an eating disorder (Garzon & Figgemeier, 2011). Lastly, life events leading to eating disorders include death of parent, divorce, and empty nest syndrome (Garzon & Figgemeier, 2011).

**Ethnic and Cultural Factors**

Ethnic and cultural factors contributing to eating disorder prevalence include immigration and acculturation. Correlation studies suggest individuals are at an increased risk for eating disorders with acculturation to western influences and immigration because stress arises from an individual trying to cope with clashes between traditional and modern values in an attempt to integrate in society (Markey Hood, Vander Wal, & Gibbons, 2009). Hispanic women, especially those born in the U.S. from foreign parents, are at greater risk for eating disorders from high acculturation levels and struggles with culture and cultural values (Markey Hood et al., 2009; National Eating Disorder Association, 2005).
**Issues in Assessment and Treatment of Eating Disorders**

**Ethnicity and Treatment-seeking Behaviors/Diagnosis**

Ethnic disparities in treatment seeking support the importance of this study in terms of the need to design culturally competent assessment approaches with women who may have an eating disorder. Cachelin et al. (2006) found that ethnicity is a strong predictor of treatment-seeking behavior for women with eating disorders, $p=0.004$. In this study, European Americans ($n=110$) were almost three times more likely to seek treatment for their eating disorders compared to Mexican Americans ($n=80$) (Cachelin et al., 2006). Additional predictors determining whether Mexican American women sought treatment for their eating disorders include lack of comorbidities and increased levels of acculturation. Of the participants who sought treatment, European Americans were almost ten times more likely to receive treatment (Cachelin et al., 2006). Factors such as high body mass indexes and later age of onset of eating disorders prevented detection of this illness.

A different study by Cachelin and Striegel-Moore (2006) also highlighted the health disparities in eating disorder treatment seeking behaviors and diagnosis. In this study, Mexican American women did not seek treatment for their eating disorders as readily as European Americans, despite similar percentages of individuals believing they had significant problems with eating. Of the 21 individuals who did seek treatment, only five diagnoses were made for eating disorders (Cachelin & Striegel-Moore, 2006). Additional differences suggested by this study include Mexican Americans are least likely to seek treatment for bulimia and are more likely to seek help from primary care providers rather than psychiatrists, receive treatment for weight problems $p=0.01$, and obtain prescriptions for diet pills (Cachelin & Striegel-Moore,
No relationships occurred with eating disorders and ethnicity in regards to psychiatric comorbidities, access to healthcare, socioeconomic status, denial of insurance, and satisfactions with healthcare services (Cachelin & Striegel-Moore, 2006).

Detection and Assessment by Clinicians

Detection of eating disorders begins at the primary care level. Approximately one-third of women with anorexia and 6% of patients with bulimia receive treatment from mental health providers, however most individuals with eating disorders seek treatment from primary healthcare providers because of associated symptomology such as dizziness, abdominal pain, and irregular menses (Linville, Benton, O’Neil, & Sturm, 2010). Unfortunately, clinician error or bias occurs in which clinicians fail to ask minorities about eating disorder behaviors, neglect to provide recommendations to see a health professional, and fail to refer minorities for further evaluation (Becker et al., 2002). Thus, healthcare disparities emerge in preventing, diagnosing, and treating eating disorders in ethnic minorities.

The literature supports the ideas of racial stereotypes and/or clinician error/bias influencing the detection of eating disorders among ethnic minorities. For example, in a study by Gordon et al. (2002), non-clinician general psychology students failed to recognize eating disorders in Hispanics and African Americans compared to Caucasians when given similar diary passages for evaluation. Moreover, in a study by Becker et al. (2003), Latinos were less likely than Caucasians to be referred for further evaluation for eating disorder symptoms, even when controlling for variances of body mass index and cognitive, behavioral, and distress scores.

In addition to addressing clinician error or bias, clinicians must overcome barriers to accessing care and seeking treatment unique to Hispanic women. Barriers to accessing care
include feelings of shame, fear of stigma, minimizing or interpreting problems differently, believing that having a therapist is a character weakness and that mental health providers are hostile, cold, and not credible, using family or informal groups as support systems, utilizing curanderos or folk healers, unfamiliarity with mental health services, and decreased levels of acculturation (Cachelin & Striegel-Moore, 2006). Barriers to seeking treatment include feelings of shame, fear of labeling, lack of knowledge on where to seek help, the severity of the illness, and beliefs that one should help themselves (Cachelin & Striegel-Moore, 2006).

Detection of eating disorders in Hispanic women is necessary to eliminate health disparities for access to care and treatment. Currently, limited research exists on validity and reliability of current assessment tools for screening for eating disorder risk among ethnic women (Franko et al., 2012). Moreover, the majority of screening tools for eating disorders were developed for Caucasian populations (Franko et al., 2012).

**Theoretical Framework**

The theoretical framework informing the practice inquiry was Choi’s (2008) *Theory of Cultural Marginality*. The purpose of this theoretical framework is to provide insight on mental health issues resulting from the migration of culturally diverse populations in the U.S. Moreover, the theoretical framework enables healthcare providers to overcome cultural background barriers to provide healthcare that is culturally relevant. Cultural competence is achieved through an increased understanding of the experiences of individuals living between two cultures.

The theoretical framework includes three key constructs that represent phenomena of cultural marginality: Acculturation, acculturative stress, and marginality (Choi, 2008). *Acculturation* consists of four concepts: assimilation, separation, integration, and marginalization.
(Choi, 2008). In acculturation, individuals with diverse cultural backgrounds come into continuous contact with a new culture, which subsequently results in changes to their culture, both cultures, or the culture in which they interact. Assimilation occurs when an individual loses their cultural identity and becomes part of the dominant culture. Conversely, separation occurs when individuals choose to live in the old culture, thus removing themselves from the dominant culture. The ideal choice is integration, in which people choose to live in both cultures while making the best of their decision. Lastly, marginalization occurs when people lose their cultural identities, in addition to the psychological contacts created with both cultures.

The second phenomenon is acculturative stress and occurs as a result of acculturation and challenges individuals to change their social behaviors and/or thought processes on how they perceive themselves in response to different social situations or environments (Choi, 2008). Specifically, acculturative stress occurs with discrimination and being different, and may result in negative mental health outcomes. The factors determining the effects on mental health include the characteristics of the individual and the nature of the dominant culture (Choi, 2008).

The third phenomenon of marginality is defined through the idea of a self-conflicted individual, living and struggling with a self that is divided between two cultures, resulting in moral turmoil, restlessness, malaise, and spiritual instability (Choi, 2008). Marginality prevents the individual from becoming part of the dominant group, with the individual subsequently living on the periphery because of experiences, status, and identity (Kim, Gonzales, Stroh, & Wang, 2006; Choi, 2008). Sympathy for oppressed or marginalized groups occurs in marginality theory when individuals themselves experience oppression (Hayes & Dowds, 2009).
Cultural marginality occurs when individual feelings are affected by cultural components such as race, ethnicity, and religion (Hayes & Dowds, 2009). Specifically, it is the feelings that arise when individuals live between two cultures, yet feel as if they do not belong to either one (Hayes & Dowds, 2009). Marginal living, a concept of the Theory of Marginality, results from a “pushing/pulling tension” of trying to exist between the two cultures while creating new relationships (Choi, 2008, p. 247). Rather than exist in the periphery, Choi’s Theory of Cultural Marginality focuses on individuals in transition between two cultures with the possibility of conflicts, losing connections with previous relationships, and promises of the future (Choi, 2008). The pushing/pulling tension of conflict versus promise results from individuals forced to choose between values, roles, norms, and expectations or positive change. Negative feelings such as anxiety, loss, identity confusion, helplessness, alienation, ambivalence, worthlessness, and apprehension for future outcomes are associated with marginal living, however these feelings may be avoided depending on how individuals perceive conflict and their ability to positively manage these challenges.

Additional concepts of this theoretical framework include across-culture conflict recognition, easing cultural tension, and contextual/personal influences (Choi, 2008). Across-culture conflict recognition occurs when individuals recognize the diversity of two different cultures and then are forced to choose between value systems. Easing cultural tension occurs in recognition of the across-culture conflict, in which individuals attempt to resolve the existing conflict through assimilation, poise, or integration. Lastly, the contextual/personal influences determine the extent of marginal living and the processes of conflict resolution and easing of cultural tension.
The *Theory of Cultural Marginality* provided a framework to understand the effects of cultural diversity on eating disorders, specifically within the Hispanic population. As previously discussed, Hispanic women fail to seek help for eating disorders because of culture induced help-seeking and treatment-seeking barriers. Notwithstanding, clinicians do not understand the complexity and prevalence of eating disorders within this population and the effects of culture on health outcomes. Given that Hispanic women are at an increased risk for developing eating disorder behavior from acculturation, the *Theory of Cultural Marginality* enables healthcare providers to identify ethnic minorities at risk for eating disorder behavior by discerning levels of acculturation.

Thus, the *Theory of Cultural Marginality* was helpful on several levels. First, areas for assessment derived from this theoretical framework were included in the pilot tool for this study. These included questions pertaining to acculturation and the relationship of this concept on eating disorder risk. Specifically, the items addressed individual acknowledgement of loss of cultural identity, feelings of isolation, and negative impact of ethnicity on eating disorder behaviors.

Second, and more broadly, the *Theory of Cultural Marginality* informs practitioners of relevant cultural issues in the context of assessing and treating eating disorders. Understanding these cultural issues facilitates the recognition of the existent acculturative stress and across-culture conflicts, how they impact the development of eating disorders, and helps the healthcare provider identify the necessary behaviors requiring modification. The theoretical framework guides the development of strategies aimed at preventing, decreasing, and or eliminating eating disorder activity. This is possible by recognizing negative response patterns and modifying them
to promote health and elicit positive mental health outcomes. Lastly, providers can modify coping strategies to improve self-esteem in Hispanic women while focusing on the goals of integration and easing of cultural tension.

**Research Questions**

1. What do Hispanic women identify and endorse as relevant areas of assessment for detection of potential eating disorders?
2. What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders?

**LITERATURE REVIEW**

Successful detection of eating disorders in the primary care setting is a difficult and challenging process that requires strong assessment skills, especially when considering culturally diverse populations. Low detection rates may be due in part to the lack of culturally sensitive assessment tools and the reluctance of individuals with eating disorders to disclose information on their aberrant eating behaviors (Evans et al., 2011). Several studies address the presence of health disparities in eating disorder recognition, access to care, and treatment for ethnic minorities, however there is a paucity of literature on how culturally sensitive healthcare providers may help overcome these barriers in their clinical assessment (Franko & Edwards George, 2008; Alegria et al., 2007; Cachelin, Striegel-Moore, & Regan, 2006; Cachelin & Striegel-Moore, 2006). This chapter presents literature on culturally competent provider behaviors and assessment tools as related to the assessment of eating disorders among Hispanic women.
Literature on Culturally Competent Provider Behaviors

In order to detect eating disorders within minority populations, healthcare providers must demonstrate culturally competent behaviors. In turn, individuals with eating disorders may more readily admit to their aberrant eating behaviors and accept treatment. Examples of culturally competent behavior include the use of specific diagnostic patterns, as well as various provider actions.

Diagnostic Patterns

Psychiatric illnesses, such as eating disorders, may be more readily detected in diverse ethnic groups through use of appropriate diagnostic patterns. Minski, Vega, Miskimer, Gara, and Escobar (2003) conducted a study in which ethnic differences of Latinos seeking behavioral healthcare compared to individuals of African and European American descent. Results indicated that improved detection rates of psychiatric illnesses were related to diagnostic patterns in inpatient and ambulatory services behavioral healthcare patients \( n=19,219 \) [Latinos=12.6\% (females=58.6\%)] (Minski et al., 2003). Examples of diagnostic patterns include use of the Spanish language, cultural status of the provider, interview format, cultural variance, and diagnostic bias (Minski et al., 2003).

Use of Spanish-speaking providers and/or individuals who were bilingual or bicultural resulted in the revelation of more personal information and more accurate assessments in the status of the patients’ physical and mental health, respectively (Minsky et al., 2003). In regards to interview format, self-assessments also elicited more data on physical and mental health in comparison to clinician assessments. Notwithstanding, providers who lacked cultural variance or used somatization by assuming Latinos are more subdued, avoidant, less assertive and have other
focus of control resulted in failure to diagnose psychiatric illness (Minski et al., 2003). Lastly, diagnostic bias resulted in incorrect diagnoses such as depression from stereotyping individuals through assumptions on cultural idioms including body language, somatic symptoms, and verbal idiosyncrasies (Minski et al., 2003).

Generalization to eating disorders of the Minski et al. (2003) study is limited to the extent that the psychiatric illness of eating disorders was not included in the study. However, pertinent results suggest that valuable information may be elicited from a focus group through use of culturally specific diagnostic patterns such as the interviewer being bilingual/bicultural. Moreover, recognition of the possible stereotypes associated with Latinos will allow for an understanding of the person as a whole, rather than based on stereotypes, thus enhancing eating disorder detection rates. Lastly, allowing the focus group participants to share their feelings using self-assessments and culturally appropriate diagnostic questions, instead of specific diagnostic tools, will provide a more accurate assessment of health status to further detect eating disorders (Appendix H).

**Provider Behavior**

Professional and non-professional support and empathy is important in treatment of eating disorders, especially in individuals who are treatment seeking (Evans et al., 2011). Moreover, it is suggested that in order to promote engagement of patients during treatment, patients be allowed some control during the treatment process (Evans et al., 2011).

Evans and colleagues (2011) conducted a four-year study in which female patients with eating disorders compared positive and negative experiences in seeking help for their illness. In a population of \( n = 57 \), positive experiences consisted of empathy and rapport, in addition to
understanding and non-judgmental approaches (Evans et al., 2011). Furthermore, individuals believed follow-up, the provision of information, and use of a direct approach were more helpful in accessing care for eating disorders (Evans et al., 2011).

Conversely, negative experience shared by subjects consisted of practitioners who would not talk to their patients or lacked people skills (Evans et al., 2011). Additional negative instances arose with providers who dismissed patients and failed to inquire about eating habits or give helpful information (Evans et al, 2011). Lastly, if patients felt they were not taken seriously or perceived judgment and stigma, their treatment for eating disorders was hindered (Evans et al., 2011).

Research suggests that advanced practice nurses are key in detecting eating disorders in women as a result of their positive patient relationships. Specifically, these healthcare professionals are known to engage in patient relationships that are long-standing and trust-worthy, and have the ability to be the “saving grace” by providing treatment and thus, potentially avoiding the physical and psychological complications associated with eating disorders (Veerman, 2013). The positive behavior has been established through being approachable and use of good communication skills that show care, concern, and focuses on the experiences of the patients (Duffin, 2013; Veerman, 2013).

Both studies were useful to the current research project to the effect that it directs the provider on how to act with patients with eating disorders. However, these studies did not examine ethnic minorities. The proposed research addressed this limitation by means of using focus groups to clarify if there is a cultural difference in preferred provider behaviors, thus aiding in the detection of eating disorders in Hispanic women.
Literature on Current Assessment Tools

As previously mentioned, a limited number of assessment tools exist for the detection of eating disorders among ethnic minorities, specifically Hispanic women. Of the tools that do exist, the majority were initially developed for Caucasians and later translated to Spanish language versions in an attempt to detect eating disorders in Spanish and/or Hispanic populations. These assessment tools include the SCOFF, Body Image Concern Inventory, Eating Disorder Inventory, Eating Disorder Examination, and Eating Disorder Examination Questionnaire.

SCOFF (Sick, Control, One, Fat, Food)

The acronym, SCOFF, uses the first letter of each of five questions addressed by the instrument and was developed with the purpose of screening individuals with anorexia and bulimia (Morgan, Reid, & Lacey, 2000). This assessment tool taps into the respondent’s self-perception in five areas of eating disorders: feeling Sick to the sensation of being uncomfortably full, losing Control over the amount of food consumed, losing more than One stone (14 pounds) within a three-month time period, feeling Fat despite being called thin, and feeling that (concerns about) Food dominates life (Morgan et al., 2000). Initially, this tool was evaluated in an English female population (n=212) ages 18-40, of which, 116 women had diagnoses of anorexia and bulimia, according to criteria from the Diagnostic & Statistical Manual of Mental Disorders (4th ed.) (Morgan et al., 2000). A control group (n=96) was used to establish validity of the SCOFF through levels of sensitivity and specificity, or the number of individuals with the disease compared to those without the illness, as determined by diagnostic tests. Results from
this study showed 100% sensitivity in detecting true cases of anorexia and bulimia with two or more positively answered questions (Morgan et al., 2000).

In a meta-analysis determining its diagnostic accuracy, the SCOFF had overall 0.801 sensitivity and 0.934 specificity in detecting anorexia, bulimia, and eating disorders not otherwise specified (Botella, Sepulveda, Huang, & Gambara, 2013). The diagnostic efficacy was significantly higher in detecting eating disorders not otherwise specified compared to anorexia and bulimia possibly due to individuals with the latter disorders hiding and denying symptoms (Botella et al., 2013). When considering solely female populations, the efficacy increased and showed a sensitivity and specificity of 0.882 and 0.925, respectively, in 9 out of 15 studies (Botella et al., 2013). Sensitivity for detecting eating disorders was decreased in evaluating individuals who had previously low weights (Botella et al., 2013).

A different study conducted by Hill, Reid, Morgan, and Lacey (2010) determined the efficacy of the SCOFF in primary care. The results showed a sensitivity of 100% for detecting true cases of anorexia and bulimia, and 84.6% for individuals with eating disorders not otherwise specified (Hill et al., 2010). Thirty-four false positives emerged in this London female population ($n=341$) (Hill et al., 2010).

The SCOFF has been translated into multiple languages to determine its validity in various ethnicities (Botella et al., 2013). Sanchez-Armass, Drumond-Andrade, Wiley, Raffaelli, and Aradillas-Garcia (2012) used the validated Spanish version of the SCOFF to determine the sensitivity of this questionnaire in a female/male population in Mexico. Of the 3,594 participants ages 16-21, a low internal consistency of 0.42 emerged for the female gender (Sanchez-Armass
et al., 2012). This consistency was considered acceptable since previous studies had similar values (Sanchez-Armass et al., 2012).

Another study by Garcia-Campayo, Sainz-Carrillo, Ibanez, Lou, Solano, and Alda (2005) tested the efficacy of the Spanish version of the SCOFF in primary care in a female population in Spain. The results of this study showed a sensitivity and specificity of 97.8%/94.4%, 93.1%/94.4%, and 100%/94.4% for bulimia, anorexia, and eating disorders not otherwise specified, respectively (Garcia-Campayo et al., 2005). Despite these high values, recommendations for use of this study included high-risk individuals and not all primary care settings. Determination of these conclusions were based on the fact that individuals chosen for this study had eating disorder symptoms and lower predictive values may result from individuals not showing to be high-risk (Garcia-Campayo et al., 2005).

In summary, this instrument was found acceptable for use in clinical populations to detect eating disorders in high-risk individuals in primary care. However, the translation of the assessment questions into Spanish does not indicate these questions are more culturally oriented and appropriate for the current subjects of interest: bilingual or monolingual Hispanic females in the U.S. Notwithstanding, the majority of Hispanic women with eating disorders have higher BMI’s, rather than BMI’s consistent with anorexia. Thus, all questions were appropriate for use in the current study since this tool had higher frequencies in detecting eating disorders such as bulimia and eating disorders not otherwise specified in comparison to anorexia.

**Body Image Concern Inventory**

The Body Image Concern Inventory was developed for use in research and clinical settings to determine dysmorphic concerns as evidenced by preoccupations with a defective
appearance, excessive self-checking, covering of defects, reassurance seeking, and avoidance of social situations (Littleton, Axsom, & Pury, 2005). Dysmorphic concerns are related to eating disorders to the effect that these concerns are associated with eating disorders signs and symptoms. Littleton et al. (2005) conducted four studies to establish the validity of the Body Image Concern Inventory and to determine if this tool had the capability to identify individuals with previous eating disorder diagnoses. Results of these studies proved this tool was internally consistent and valid in detecting dysmorphic concern. Moreover, the Body Image Concern Inventory highly correlated with the Eating Disorder Inventory, a well-established tool for assessing eating disorders ($r=0.62$, $p<0.001$), when studying a sample ($n=200$) of undergraduate students in which 80% were female (Littleton et al., 2005).

The Body Image Concern Inventory was also translated to the Spanish language for validation in Hispanic female populations. Littleton and Breitkopf (2008), examined a sample ($n=1,616$) of low socioeconomic status women ages 18-55 in which 1,043 individuals completed an English language version of the Body Image Concern Inventory, while 573 women completed a Spanish language version. In the sample, 34% of the English language and 99% of the Spanish language version identified themselves as Hispanic or Latina. Individuals completing the Spanish language version were born in the U.S. (2%), Mexico (83%), and other countries (14%) (Littleton & Breitkopf, 2008). Results showed acceptable internal consistencies in validation of the English language version of the Body Image Concern Inventory in a diverse ethnic population of low socioeconomic status women when considering dysmorphic concern and interference due to appearance concern (Littleton & Breitkopf, 2008). In regards to ethnicity, higher scores on the Body Image Concern Inventory were evident in European American women.
compared to Latina or African Americans, however when comparing Latina women, those born in the U.S. scored higher (Littleton & Breitkopf, 2008).

In conclusion, the Body Image Concern Inventory was appropriate for the current population of interest since Littleton and Breitkopf (2008) included Latina women living in the U.S., rather than in a foreign country. However, this tool had not been validated for use in the primary care setting. As with the SCOFF, translation of the Body Image Concern Inventory into Spanish does not guarantee the questions are more culturally relevant. However, since there was a higher prevalence in Latina response to the subscales of dysmorphic concern and interference due to appearance concerns, questions within these subjects may be appropriate for the current study. Moreover, questions concerning use of diet pills and skipping meals may be appropriate since Latina women with these issues had higher scores within this assessment tool. Highest scoring questions with frequencies of greater than 80% that were included in the current study are questions: 16) I have missed social activities because of my appearance. (He perdido actividades sociales por mi apariencia.); 17) I have been embarrassed to leave the house because of my appearance. (Ha estado avergonzada de salir de mi casa por causa de mi apariencia.); and, 18) I fear that others will discover my flaws in appearance. (Tengo miedo a que otros descubran las fallas en mi aspecto físico.) (Littleton & Breitkopf, 2008, p. 387).

**Eating Disorder Inventory and its Derivatives**

The Eating Disorder Inventory (EDI), created by Garner, Olmstead, and Polivy (1983) is a self-report consisting of eight subscales and 64-items. This assessment tool was designed to assess individuals with anorexia nervosa and bulimia and their associated psychological and behavioral traits. Initial validation of this tool occurred with the completion of four studies in
North America, in which women with anorexia (n=113, mean age=21.8) were compared to female university psychology students (n=577) (Garner et al., 1983). Secondly, women with bulimia (n=195), obesity (n=44), formerly obese (n=52), and recovered women with anorexia (n=17) were compared to a group of males (n=166). Additional studies consisted of self-report patient profiles in comparison to clinical judgments, and cross validation of the Eating Disorder Inventory to existing tools such as the Eating Attitudes Test and Hopkins Symptom Check List (Garner et al., 1983). All studies showed reliability and validity with average item internal consistency scores of 0.63 (SD=0.13) (Garner et al., 1983).

The Eating Disorder Inventory-3 (EDI-3) was developed from the Eating Disorder Inventory to assess eating disorders among culturally diverse individuals (Clausen, Rosenvinge, Friborg, & Rokkedal, 2011). This assessment tool was modified to include 12 subscales and 91 items. Validation of the Eating Disorder Inventory-3 occurred with the purpose of establishing national norms and to determine the efficacy of the subscales and items in discriminating between eating disorders (Clausen et al., 2011). Using a Danish population, Clausen et al. (2011) found that the Eating Disorder Inventory-3 significantly detects eating disorders in females with anorexia and bulimia (n=561, ages 18-54) compared to a control group (n=878, ages 18-30), thus establishing national norms, with high effect sizes on all subscales excluding the Drive for Thinness category (Clausen et al., 2011).

The Eating Disorder Risk Composite (EDRC) is a modification of the Eating Disorder Inventory-3 and consists of the subscales Drive for Thinness, Body Dissatisfaction, and Bulimia (Cordero, Julian, & Murray, 2013). This tool was developed to detect eating disorder symptoms in Latina college women and was validated in a population of psychology students in southern
California \((n=238,\) ages 18-51) (Cordero et al., 2013). Results of this study showed the subscales- Drive for Thinness and Body Dissatisfaction are “often” experiences of Latina college women, and that this population is “seldom” affected by items under the Bulimia subscale (Cordero et al., 2013). Moreover, Latina women were more concerned with having a stomach that is too big and overall body shape. Conversely, items of least concern were the size of the abdomen being just right, buttocks being too large, and sensations of feeling bloated (Cordero et al., 2013). Lastly, negative feelings on consuming sweets did not influence an individuals’ drive for thinness, nor was purging a factor in controlling weight in bulimia. This study showed a reliability of >0.80 and was considered clinically relevant since results were similar to previous studies (Cordero et al., 2013).

In conclusion, the Eating Disorder Inventory and its derivatives were not feasible to use clinically because of the lengthiness. Moreover, the Eating Disorder Risk Composite has not been validated for use in primary care. Despite these issues, cultural relevance may be implied through statements identified in the Eating Disorder Risk Composite such as “I think my stomach is too big” and “I feel satisfied with the shape of my body” based on participant response (Garner et al., 1983). Thus, these items were of use for the current study to detect eating disorders in Hispanic women.

**Eating Disorder Examination and its Questionnaire Derivative**

Cooper and Fairburn (1987) introduced the *Eating Disorder Examination* for the purpose of enabling a detailed evaluation of the psychopathology of eating disorders. The 62-item semi-structured interview focuses on body shape and weight concerns in individuals with anorexia and bulimia. Using a sample consisting of raters \((n=3)\), women with bulimia \((n=9)\), and women
without eating disorders \((n=3)\), inter-rater reliability was obtained on all items with correlation coefficients ranging from 0.69 to 1.00 (Cooper & Fairburn, 1987). Additional validation of the Eating Disorder Examination occurred with the creation of five subscales (restraint, bulimia, eating concern, weight concern, and shape concern) based on groupings of similar items (Cooper, Cooper, & Fairburn, 1989). Internal consistency of the subscales was evaluated using a British female sample, age 18-35, of women with anorexia \((n=47)\), women with bulimia \((n=53)\), and a control group \((n=42)\) (Cooper et al., 1989). Data showed internal consistencies of 0.67 to 0.90 of the 32-items selected, specifically with exclusion of sensitivity to weight gain and pursuit of thinness, since these items resulted in lower clinical significance (Cooper et al., 1989).

The Eating Disorder Examination interview was translated to the Spanish language to detect eating disorders in minority groups. Moreover, this tool was used to detect eating disorder symptomology over a short time period, that is, over the previous 28 days. Using a group of community dwelling Spanish-speaking only Latina women in the U.S., inter-rater and short-term test-retest reliability was established (Grilo, Lozano, & Elder, 2005). Overall, inter-rater reliability intraclass correlation coefficients were 0.99, 0.55, and 0.88 to 0.98 for objective bulimic episodes, subjective bulimic episodes, and the Spanish-Eating Disorder Examination subscales, respectively (Grilo et al., 2005). In regards to short-term test-retest, intraclass coefficients were 0.79, 0.22, and 0.67 to 0.90 for objective bulimic episodes, subjective bulimic episodes, and the Spanish-Eating Disorder Examination subscales, respectively (Grilo et al., 2005). Based on results from this study, recommendations were for preliminary support of the Spanish language version of the Eating Disorder Examination, as well as a need for further research for additional validation.
Since previous studies lacked empirical support for the factor structure of the Eating Disorder Examination, Grilo et al. (2012) conducted a study to test the factor structure efficacy of the Spanish-Eating Disorder Examination. Using a sample of Spanish-speaking only participants ($n=156$, mean age 44.1, females=141, males=15, mean BM=33.2), results of this study suggest adequacy of internal consistency for the subscales of the Eating Disorder Examination (Grilo et al., 2012). However, results also showed a poor fit of the original Eating Disorder Examination and its subscales based on confirmatory factor analysis (Grilo et al., 2012). A good fit was obtained with a modified version of the Spanish-Eating Disorder Examination in which cultural concepts relevant to the Latino culture were selected and limited to a seven-item construct, rather than the original four-item (Grilo et al., 2012).

Overall, even though the previous study had males, results suggest items derived from the Spanish-Eating Disorder Examination were useful in detecting eating disorders in Hispanic women with higher BMIs. Cultural concepts considered for this study include restraint over eating, food avoidance, dietary rules, and importance/dissatisfaction of shape and weight (Grilo et al., 2012). Unfortunately, this tool is quite lengthy and had not been tested in primary care, thus its use in the current study may be negligible.

**Eating Disorder Examination Questionnaire**

The Eating Disorder Examination Questionnaire was adapted from the Eating Disorder Examination to create a 41-item self-report to assess eating disorder behaviors and psychopathology with the use of four subscales (restraint, shape concern, weight concern, and eating concern) (Luce & Crowther, 1999). A study, conducted by Luce and Crowther (1999), determined the internal consistency and test-retest reliability of this tool using a sample of mid-
western female undergraduate students \((n=139,\ \text{average\ age\ 18.5,\ average\ BMI}=22.5,\ \text{Hispanic}=1\%)\) (Luce & Crowther, 1999). Results of this study showed reliability occurrence scores ranging from 0.57 to 0.70 and reliability frequency scores of 0.54 to 0.92 (Luce & Crowther, 1999). Internal consistency scores ranged from 0.78 to 0.93 (Luce & Crowther, 1999). Overall, this study was statistically significant in the use of four subscales as a self-report measure and in regards to measuring eating disorder behaviors such as binge eating, self-induced vomiting, laxative misuse, and diuretic misuse.

Mond, Hay, Rodgers, Owen, and Beaumont (2004) conducted a study to validate the use of the Eating Disorder Examination Questionnaire as a screening tool for assessing eating disorder behavior and attitudes within the general population. Using an Australian female sample \((n=208,\ \text{ages\ 18-45})\), it was concluded the questionnaire highly correlates across the subscales \((r=0.68\ \text{to}\ 0.84)\): restraint, eating concerns, weight concerns, and shape concerns, when compared to the Eating Disorder Examination interview (Mond et al., 2004). Moreover, individuals scored higher on all items within the questionnaire excluding the topics: ‘restraint overeating,’ ‘food avoidance,’ ‘eating in secret,’ ‘importance of weight,’ and, ‘importance of shape.’ Despite the high correlations, low positive predictive values occurred in the assessment of binge eating, while high predictive values were present in the detection of objective bulimic episodes in occurrence and frequency (Mond et al., 2004). Lastly, results were unambiguous in regards to restraint and greater discrepancies occurred with the subscale concerning shape and were minimal in the importance of shape and weight (Mond et al., 2004).

Elder and Grilo (2007) validated the use of the Spanish language version of the Eating Disorder Questionnaire and short-term test-retest reliability in comparison with the Spanish
language Eating Disorder Examination using an urban U.S. sample of Spanish speaking Latina women \((n=77, \text{ mean age}= 41.5)\). Results of this study showed significant correlations in binge eating with objective bulimic episodes and subjective bulimic episodes \((r=0.30, r=0.39)\), on all individual items, and within the with four subscales \((r=0.67 \text{ to } 0.80)\): overeating behaviors, eating concern, weight concern, and shape concern, with higher scores in the latter three subscales in the Spanish questionnaire (Elder & Grilo, 2007). Short-term test-retest reliability showed high consistencies (Spearman rho 0.71 to 0.81) in the subscales: restraint, eating concern, weight concern, and shape concern and modest consistency in binge eating (Elder & Grilo, 2007). Since the frequency of inappropriate weight compensatory behaviors such as purging was too low, short-term test-retest reliability could not be calculated.

In summary, factors limiting the use of this eating disorder assessment tool and its derivatives in the current study were its lengthiness and the absence of being tested in primary care settings. Moreover, this tool was conducted using a monolingual Spanish speaking population and the current subjects were bilingual or English speaking. Despite these factors, items of use to the current study pertained to eating, weight, and shape concerns since these items yielded higher scores in identifying eating disorder behavior among Latina women, when compared to the Eating Disorder Examination (Elder & Grilo, 2007).

**Summary of Literature Review**

Although many studies have emphasized the importance of addressing eating disorders in ethnic minorities, there is a paucity of studies that look at clinically effective strategies to assess and detect these disorders in a manner that is clinically feasible and relevant. This can be accomplished with the development of a brief assessment tool and concise clinical guidelines
focusing specifically on the values and beliefs of the population of interest. The need for a culturally-relevant protocol is underscored by the fact that while the American-Hispanic population is growing, Hispanic women are no less subject to the iatrogenic impact of the global culture that promotes an ultra-thin ideal for women, nor are Hispanic women immune to the deadly impact of disordered eating.

**METHOD**

This study surveyed Hispanic women diagnosed with an eating disorder to initially test the relevance and clarity of items in an investigator-developed tool to assess eating disorders. Guidelines for provider behaviors were also examined. Eventually, the assessment tool and guidelines may be used in the clinical setting. Two research questions were addressed:

1. What do Hispanic women identify and endorse as relevant areas of assessment for detection of potential eating disorders?

2. What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders?

**Design**

The design for this descriptive research was a cross-sectional, non-experimental study. The research questions were addressed by means of obtaining quantitative data on a newly developed tool and obtaining qualitative data through focus groups. The findings were used to refine the assessment tool and establish clinical guidelines to aid in the detection of eating disorders. Lastly, the use of discussion from focus groups of patients with eating disorders
provided knowledge on culturally sensitive information to help providers engage in a discussion of eating disorders among Hispanic women.

**Sample/Setting**

Five female participants of Hispanic/Latina ethnicity with diagnosed eating disorders were recruited through purposeful convenience sampling from patients responding to recruitment flyers (Appendix D) posted at multiple eating disorder and other clinical settings in Albuquerque and Rio Rancho, NM. Additional participants were recruited from the Eating Disorders Institute of New Mexico emailing list.

Inclusion criteria for the participants were as follows:

1. Women ages 18-45.
2. Diagnosis of an eating disorder.
3. Female gender.
5. English speaking.
6. Able to read and write in English.

Individuals who did not meet all six-inclusion criteria were ineligible for the study.

**Instruments**

Three questionnaires, all developed by the investigator, were used in the study: The Risk Assessment of Eating Disorders (RAED) tool, Preferred Provider Behaviors Guidelines Questionnaire, and a Demographic and Health-Related Questionnaire. These questionnaires are found in Appendix A.
Description of RAED

Given that there are no existing validated culturally sensitive assessment tools to evaluate the risk of developing eating disorders, the RAED for Hispanic women was developed by the investigator (Appendix A). The 32-items (Table 1) that comprise this tool were adapted from a review of the literature on existing questionnaires on the basis of having been found to be culturally appropriate to Hispanic/Latina samples.

**TABLE 1. RAED Items**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you make yourself sick because you feel uncomfortably full?</td>
</tr>
<tr>
<td>2.</td>
<td>Do you worry you have lost control over how much you eat?</td>
</tr>
<tr>
<td>3.</td>
<td>Do you believe yourself to be fat when others say you are too thin?</td>
</tr>
<tr>
<td>4.</td>
<td>I seek reassurance from others about my appearance.</td>
</tr>
<tr>
<td>5.</td>
<td>Have you recently lost more than fourteen pounds in a 3-month period?</td>
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<tr>
<td>6.</td>
<td>Would you say that food dominates your life?</td>
</tr>
<tr>
<td>7.</td>
<td>I spend a significant amount of time checking my appearance in the mirror.</td>
</tr>
<tr>
<td>8.</td>
<td>I feel others are speaking negatively of my appearance.</td>
</tr>
<tr>
<td>9.</td>
<td>I compare my appearance to that of fashion models or others.</td>
</tr>
<tr>
<td>10.</td>
<td>I try to camouflage certain flaws in my appearance.</td>
</tr>
<tr>
<td>11.</td>
<td>I examine flaws in my appearance.</td>
</tr>
<tr>
<td>12.</td>
<td>I have bought clothing to hide a certain aspect of my appearance.</td>
</tr>
<tr>
<td>13.</td>
<td>I feel others are more physically attractive than me.</td>
</tr>
<tr>
<td>14.</td>
<td>I have missed social activities because of my appearance.</td>
</tr>
<tr>
<td>15.</td>
<td>I have been embarrassed to leave the house because of my appearance.</td>
</tr>
<tr>
<td>16.</td>
<td>I fear that others will discover my flaws in appearance.</td>
</tr>
<tr>
<td>17.</td>
<td>I have participated in unhealthy dieting behaviors such as using diet pills to control my weight.</td>
</tr>
<tr>
<td>18.</td>
<td>I have skipped meals to control my weight.</td>
</tr>
<tr>
<td>19.</td>
<td>I do not feel satisfied with the shape of my body.</td>
</tr>
<tr>
<td>20.</td>
<td>I am preoccupied with the shape of my body.</td>
</tr>
<tr>
<td>21.</td>
<td>I feel that my stomach is too big.</td>
</tr>
<tr>
<td>22.</td>
<td>I want to be thinner.</td>
</tr>
<tr>
<td>23.</td>
<td>I am preoccupied with food and calories.</td>
</tr>
<tr>
<td>24.</td>
<td>I eat in secret.</td>
</tr>
<tr>
<td>25.</td>
<td>I feel guilty about eating.</td>
</tr>
<tr>
<td>26.</td>
<td>I have a fear of fatness.</td>
</tr>
<tr>
<td>27.</td>
<td>I have discomfort when seeing my body.</td>
</tr>
<tr>
<td>28.</td>
<td>I have feelings of fatness.</td>
</tr>
<tr>
<td>29.</td>
<td>I avoid food.</td>
</tr>
<tr>
<td>30.</td>
<td>I feel weight is important.</td>
</tr>
<tr>
<td>31.</td>
<td>I am preoccupied with weight.</td>
</tr>
<tr>
<td>32.</td>
<td>I am dissatisfied with my weight.</td>
</tr>
</tbody>
</table>
An additional three questions were developed using the *Theory of Cultural Marginality* to assess the stress and/or tension respondents experience as a function of ethnicity and culture and these effects on eating disorders. These questions are: 1) Do you feel that your ethnicity negatively impacts your eating behaviors?; 2) I feel I have lost my cultural identity as a result of my preoccupations with food; and, 3) I feel that I am isolated from my culture because of my preoccupations with food.

A culturally sensitive Likert-type scaling technique with thorough descriptions of each response was used to reduce cultural bias and allow for an increased understanding of the questions presented (Flaskerud, 2012). The description allows for more culturally diverse participants, in addition to those with minimal formal education, to provide more informed responses. The response scaling for the RAED Likert-type scale used in the practice inquiry are: 1) Not at all relevant; 2) Mostly not relevant; 3) Somewhat relevant; 4) Very relevant; and, 1) Not at all clear; 2) Mostly not clear; 3) Somewhat clear; 4) Very clear. Scores were given to each response ranging from one to four. Two sets of responses, pertaining to relevance and clarity, were obtained on each item of the tool.

**Preferred Provider Behaviors Guidelines Questionnaire**

Two questions were created to determine if there is a cultural difference in preferred provider behavior and interactions that would enable patients to volunteer specific information about their eating disorder, thus aiding in the detection of eating disorders among Hispanic women in the primary care setting (Appendix A). These questions were: 1) What types of provider behavior would help you to volunteer specific information about your eating disorder so
that these individuals can detect them in the primary care setting?; and, 2) What types of provider behavior would inhibit you from admitting you have an eating disorder?

**Demographic and Health-Related Questionnaire**

A demographic and health-related questionnaire was also used to obtain descriptive information on each participant (Appendix A). The items in this questionnaire are listed as follows: Gender, age, ethnicity, preferred language, ability to read and write in English, country of origin, current city of residence, type of eating disorder, who diagnosed the eating disorder, and length of eating disorder time.

**Procedure**

The study was IRB approved prior to data collection (Appendices B and G contains required IRB documentation). Procedures to obtain informed consent were followed. Lastly, a human subjects’ acknowledgement form was completed prior to individual participation. Refreshments were provided and participants received a $25 monetary gift card to Wal-Mart or Target for their involvement.

Data collection for the study occurred during a one-hour audio-recorded interview of the eating disorder focus group. Individuals, who expressed discomfort in a group setting but wished to participate in the study, were allowed to meet on a separate day. Each participant started the process by completing the questionnaire requesting demographic and health related information. Next, each participant completed the RAED tool, and rated each item on relevance and clarity as perceived by her as a Hispanic woman with an eating disorder. Lastly, the participants were asked questions on recommendations of culturally appropriate provider behavior that would help
them volunteer specific information about their eating disorders, in addition to behaviors that would inhibit them from admitting they engage in abnormal eating activity.

**Data Analysis**

The Statistical Package for the Social Sciences (SPSS) Version 22 was utilized to summarize the demographic and health characteristics using descriptive statistics for each focus interview. Data was tallied on each item within the RAED tool for relevance and clarity. Variability in the descriptive statistics was assessed with measurements such as percentage, means, and standard deviation. Lower scored items were discarded and higher scored items maintaining at least 75% agreement were saved. Qualitative data from focus group responses was used to evaluate the RAED items along with the quantitative results. The assessment tool was modified by the elimination or addition of items generated through discussion.

The next step in the data analysis was the creation of frequency distributions. The distributions were used to determine the patterns in regards to the relevance of items to the population of interest and clarity of questions within RAED. Completion of these distributions was in response to question one of the research project. Qualitative data from focus interview responses was used to evaluate the RAED items along with the quantitative results.

In regards to the research question, “What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders?” Open-ended questions were asked during the interviews. Ideas were discussed until themes were generated by a qualitative content analysis. These themes were used to create clinical guidelines on culturally appropriate provider behavior.
RESULTS

Demographics, health information, and the results of the tool on frequency of relevance and clarity are presented within this chapter. In addition, the themes generated by participants on provider behavior, in the primary care setting, that would either help or hinder Hispanic women in volunteering specific information about their eating disorder is included. The overall goal of the study is to develop a refined and shortened version of the Risk Assessment for Eating Disorders (RAED) tool for Hispanic women, comprised of 14 questions, for use in primary care. Moreover, clinical guidelines on culturally competent questions and provider behaviors or interactions were compiled based on the feedback from the women with eating disorders.

Description of Sample

The sample consisted of five Hispanic female participants, with one participant identifying herself as Hispanic/Irish. Data collection occurred from March 2016 to May 2016. Individuals for the study responded to recruitment fliers from the Eating Disorders Institute of New Mexico. A healthcare provider who received an email invitation (Appendix E) for participants via the Eating Disorders Institute of New Mexico emailing list referred an additional participant for the study.

Ages of participants ranged from 19 to 32 with a mean age of 26 years (standard deviation \(SD = 5.0\) years). Participants, with the exception of one individual who resides in El Paso, Texas (20%, \(n=1\)), reside in one of the New Mexico cities: Albuquerque (60%, \(n=3\)) and Las Cruces (20%, \(n=1\)). The types of eating disorders among the population surveyed is anorexia (20%, \(n=1\)), anorexia/bulimia (60%, \(n=3\)), and anorexia (purging)/bulimia (20%, \(n=1\)). Each woman had been diagnosed as having an eating disorder by either their primary care provider
and psychiatrist (20%, n=1), psychiatrist (40%, n=2), or psychologist (40%, n=2), with length of eating disorder time since diagnosis ranging from 4-18 years (mean $[M]=8.80$, $SD=5.6$).

**Research Question One**

*What do Hispanic women identify and endorse as relevant areas of assessment for detection of potential eating disorders?*

Overall, the results indicated that the assessment tool contained items that were relevant to the participants. They also reported that most items were perceived as clear or understandable. The frequency rating on overall relevance showed a mean of 3.6 ($SD = 0.4$), with a range of 2.2 to 4.0, for the 35 items within the tool. Overall clarity generated a mean of 3.9 ($SD = 0.2$), with a range of 3.4 to 4.0.

Specifically, all five participants rated a 4.0 relevance score on items: 3, 6, 17, 18, 20, 22, 27, 28, 30, and 32 (Table 2). These items pertained to dysmorphic, food, and shape concerns, as well as dieting behaviors. The lower scoring items with an average relevance score below the mean of 3.6 were items: 1, 2, 4, 5, 8, 12, 16, 29, 33, 34, and 35 (Table 2). These items addressed individual concerns over appearance, food control and avoidance of food, weight loss, and effects of ethnicity and culture on eating disorder activity. Items 4 and 8 showed the smallest standard deviation of 0.8 and were specific to seeking reassurance about ones’ appearance, in addition to concern of others speaking negatively of said appearance (Table 2).

All five participants rated a 4.0 clarity score on items 1, 3, 5, 6, 7, 9, 12, 13, 15, 17, 18, 19, 21, 22, 23, 24, 25, 26, 31, and 32 (Table 2). These items pertained to weight loss, dieting behaviors, overeating and dysmorphic, food, appearance and body shape concern. The lower scoring items with an average clarity score below 3.8 were 2, 20, 27, 28, 33, and 34 (Table 2).
These items addressed control over eating, preoccupations with body shape, feelings of fatness, and ethnic and cultural impacts on eating disorder behavior. Items 2 and 34 had the smallest standard deviation of 0.5 and discussed loss of control over eating and loss of cultural identity from preoccupations with food (Table 2).

The items showing a combined average relevance and clarity score of 4.0 were 3, 6, 17, 18, 22, and 32 (Table 2). These items focused on feelings of fatness, food concerns, dieting behaviors and body shape and weight concerns. The items showing a combined average relevance and clarity score of 3.9 were 7, 19, 21, 23, 24, 26, 30, and 31 (Table 2). Preoccupation with food, eating habits, and concerns on appearance, shape, and weight were the common ideas associated with this score. The remainder of items had an average relevance and clarity score ranging from 2.9 to 3.8, with a mean of 3.6. See Table 2 for a complete list of average relevance and clarity scores, in addition to the combined means, for each item.

TABLE 2. Overall Mean Relevance, Clarity and Combined Scores.

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean Relevance</th>
<th>Mean Clarity</th>
<th>Mean Combined Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you make yourself sick because you feel uncomfortably full?</td>
<td>3.2</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>2. Do you worry you have lost control over how much you eat?</td>
<td>3.4</td>
<td>3.6</td>
<td>3.5</td>
</tr>
<tr>
<td>3. Do you believe yourself to be fat when others say you are too thin?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>4. I seek reassurance from others about my appearance.</td>
<td>3.2</td>
<td>3.8</td>
<td>3.5</td>
</tr>
<tr>
<td>5. Have you recently lost more than fourteen pounds in a 3-month period?</td>
<td>3.0</td>
<td>4.0</td>
<td>3.5</td>
</tr>
<tr>
<td>6. Would you say that food dominates your life?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>7. I spend a significant amount of time checking my appearance in the mirror.</td>
<td>3.8</td>
<td>4.0</td>
<td>3.9</td>
</tr>
<tr>
<td>8. I feel others are speaking negatively of my appearance.</td>
<td>3.2</td>
<td>3.8</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Score1</td>
<td>Score2</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>9</td>
<td>I compare my appearance to that of fashion models or others.</td>
<td>3.6</td>
<td>4.0</td>
</tr>
<tr>
<td>10</td>
<td>I try to camouflage certain flaws in my appearance</td>
<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td>11</td>
<td>I examine flaws in my appearance</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>12</td>
<td>I have bought clothing to hide a certain aspect of my appearance</td>
<td>3.4</td>
<td>4.0</td>
</tr>
<tr>
<td>13</td>
<td>I feel others are more physically attractive than me</td>
<td>3.6</td>
<td>4.0</td>
</tr>
<tr>
<td>14</td>
<td>I have missed social activities because of my appearance</td>
<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td>15</td>
<td>I have been embarrassed to leave the house because of my appearance</td>
<td>3.6</td>
<td>4.0</td>
</tr>
<tr>
<td>16</td>
<td>I fear that others will discover my flaws in appearance</td>
<td>3.4</td>
<td>3.8</td>
</tr>
<tr>
<td>17</td>
<td>I have participated in unhealthy dieting behaviors such as using diet pills to control my weight.</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>18</td>
<td>I have skipped meals to control my weight</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>19</td>
<td>I do not feel satisfied with the shape of my body</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>20</td>
<td>I am preoccupied with the shape of my body</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>21</td>
<td>I feel that my stomach is too big</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>22</td>
<td>I want to be thinner</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>23</td>
<td>I am preoccupied with food and calories</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>24</td>
<td>I eat in secret</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>25</td>
<td>I feel guilty about eating</td>
<td>3.6</td>
<td>4.0</td>
</tr>
<tr>
<td>26</td>
<td>I have a fear of fatness</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>27</td>
<td>I have discomfort when seeing my body</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>28</td>
<td>I have feelings of fatness</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>29</td>
<td>I avoid food</td>
<td>3.2</td>
<td>3.8</td>
</tr>
<tr>
<td>30</td>
<td>I feel weight is important</td>
<td>4.0</td>
<td>3.8</td>
</tr>
<tr>
<td>31</td>
<td>I am preoccupied with weight</td>
<td>3.8</td>
<td>4.0</td>
</tr>
<tr>
<td>32</td>
<td>I am dissatisfied with my weight</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>33</td>
<td>Do you feel that your ethnicity negatively impacts your eating behaviors?</td>
<td>2.8</td>
<td>3.4</td>
</tr>
<tr>
<td>34</td>
<td>I feel I have lost my cultural identify as a result of my preoccupations with food.</td>
<td>2.2</td>
<td>3.6</td>
</tr>
<tr>
<td>35</td>
<td>I feel that I am isolated from my culture because of my preoccupations with food.</td>
<td>2.8</td>
<td>3.8</td>
</tr>
</tbody>
</table>
Research Question Two

What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders?

Several common themes were generated in response to positive provider behavior that would enable Hispanic women to volunteer specific information about their eating disorders (Table 3). The provider behavior or interactions that elicited positive responses include behaviors or interactions that were empathetic ($n=3$). In addition, the women with eating disorders preferred providers who were not overly analytical and focused on the eating disorder itself, rather than other medical conditions ($n=4$). Lastly, participants were willing to talk to clinicians who asked them direct questions ($n=2$), looked at the overall picture ($n=4$), and to those who would sit down and talk with the patient, rather than writing on a clipboard or looking at a computer ($n=3$).

TABLE 3. Positive Provider Behavior.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showing empathy</td>
<td>I think a female provider would catch on to that better, there would be more empathy I think.</td>
</tr>
<tr>
<td>Avoid being over analytical</td>
<td>Not so analytical, trying to narrow down other medical issues and actually focusing on the eating disorder.</td>
</tr>
<tr>
<td>Asking direct questions</td>
<td>For me personally, I would find the direct approach to be helpful…especially because I think a lot of time the issue is admitting it to yourself and sometimes you just need somebody else to ask that question. If somebody was willing to recognize it…it would be much easier for me to acknowledge that…recognizing that it had gotten out of control.</td>
</tr>
<tr>
<td>Looking at the overall picture</td>
<td>I think looking out for those signs, looking at the overall picture, instead of just that session…my doctor could have picked up more if he would have looked at…“you know, this girl is always in here, there is nothing really wrong with her, but we see her a lot, what could that be?”…They always told me it was stress…not really looking at what the underlying cause was.</td>
</tr>
<tr>
<td></td>
<td>Maybe just checking in on the overall because, not always, but usually, there’s something underlying when it comes to eating disorders.</td>
</tr>
</tbody>
</table>
TABLE 3. - *Continued*

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being willing to sit down with the patient and put down the clipboard/notes</td>
<td>I remember being very impressed by doctors that were willing to…sit down and put down the clipboard or the notes…and look you in the eye and have a conversation with you, and it not just be about whatever they are writing down or typing on the computer or looking up the med charts, like having a conversation, and being 100% available. If it wasn’t so like they were just writing down on the clipboard, more like, “hey can we talk.”</td>
</tr>
</tbody>
</table>

Themes on provider behaviors or interactions that would inhibit Hispanic women from admitting to their disordered eating emerged during the interviews (Table 4). For example, participants preferred talking to providers who did not ask direct questions \((n=2)\) or were in a hurry \((n=3)\). Participants were also inclined to avoid talking to providers who were judgmental \((n=3)\), and to those who would talk about weight changes \((n=3)\).

**TABLE 4. **Negative Provider Behavior.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking direct questions</td>
<td>I don’t think a direct approach would be very beneficial. I feel like a lot of people don’t admit it to themselves that it’s an eating disorder, so asking somebody and then leaving it at at wouldn’t be helpful. I don’t really know if directly asking a question is effective because…people who might have an eating disorder don’t know it.</td>
</tr>
<tr>
<td>Being in a hurry</td>
<td>If they were in a hurry, and they were just kind of trying to rush me in and out… It’s a difficult enough thing to talk to about without feeling “Oh great, I’ve got 5 minutes to talk to this guy who’s clearly no interest in hearing about what I was thinking or feeling or anything.” I know it’s a hard thing to ask your primary care doctor, but not so rushed and it’s hard because they are rushed, but more than just like “Oh do you have an eating disorder? No, okay, moving on.”</td>
</tr>
<tr>
<td>Being judgmental</td>
<td>…if they had established at least with me a history of being judgmental and all the things that sort of render someone unapproachable, you know.</td>
</tr>
<tr>
<td>Avoid focusing on weight loss or gain</td>
<td>At the time that I was diagnosed with my eating disorder…it was very important to me that she take it seriously and not treat it as a vanity disorder, or just tell me that “Oh, I’ve noticed that you’ve lost weight since the last time I saw you.”</td>
</tr>
</tbody>
</table>
DISCUSSION

The purpose of this chapter is to discuss the findings of each research question and make recommendations regarding the relevance of the theoretical framework informing this study-Choi’s (2008) Theory of Cultural Marginality. Limitations are also presented. Lastly, the implications for future research and practice are discussed.

Research Question One

*What do Hispanic women identify and endorse as relevant areas of assessment for detection of potential eating disorders?*

The Hispanic women in this study identified and endorsed several items within the Risk Assessment of Eating Disorders (RAED) tool as areas of assessment for detection of potential eating disorders. The items that these women identified and endorsed were used to create a refined and shortened version of RAED, comprised of 14 items, feasible for use in the primary care setting (Appendix C). These items were chosen because they received the highest combined relevance and clarity mean scores of 3.9 to 4.0. The lower scoring items were excluded from the final tool.

During the focus interviews, participants identified why some items received lower scores in regards to relevance and clarity. Specifically, the women with anorexia who were prone to engage in restricting food behavior claimed they would not make themselves sick due to being uncomfortably full or lose control over how much they ate. Thus, items 1 and 2 received low relevance scores because these items were not congruent with their eating disorder. In regards to clarity, it was suggested that item 2 include specifics such as eating too little or too much when inquiring of the loss of control a person with eating disorders experiences while consuming food.
Items 4, 8, and 16 were thought to be less relevant by participants because the majority of the women did not seek reassurance from others or feel that others were speaking negatively about their appearance. Moreover, they did not fear that others would discover the flaws in their appearance. One woman stated she had never cared about what other people thought of her; rather the importance was in how she felt about herself. She was also not concerned about others discovering flaws in her appearance but more about her own discovering of these flaws. A second participant claimed she would like to hear from others that her clothes looked okay and that she was not fat, however she never sought out these comments or validation. An additional participant stated that she knew rather than felt that others were speaking negatively of her appearance. The woman stated her husband’s father was very much the “masculine macho man Hispanic husband” and he would always comment on her weight fluctuations.

Items 28 and 29 were also discarded due to low clarity and relevance scores. The women felt that item 28 should be more specific to the type of discomfort they experienced when they saw their body. For example, one participant stated she did not know if the discomfort was in regards to physical or mental anguish. Regarding item 29, participants admitted that they did not avoid food; rather they were obsessed with food. One participant constantly measured the food she cooked. Another woman stated she had to eat snacks and balanced meals because, despite being a female with anorexia, she was also hypoglycemic.

Items 33, 34, and 35 were also thought to be irrelevant by participants. The majority of participants felt that their eating disorder did not have anything to do with their culture. This same reasoning was used for the low clarity scores on the latter two items. One woman stated she lost herself as a whole, rather than just her culture, from being obsessed with being thin and that
nothing else mattered. Another woman stated her Hispanic culture embraces curves, identifies beauty in “chubbier” women, and considers heavier women of higher status since they can afford to eat. Thus, she felt that her ethnicity did not negatively impact her eating disorder of anorexia. A third participant stated cultural social factors affected her eating disorder rather than her ethnicity since she grew up in a predominantly Caucasian neighborhood.

In comparing the final version of the tool with the previous literature review, seven of the 14 items generated were from the Eating Disorder Examination assessment tool. This was most likely the result of this questionnaire being developed initially to identify the body shape and weight concerns in individuals with anorexia and bulimia, conditions of which the sample population had been diagnosed (Cooper & Fairburn, 1987). Moreover, the participants identified with the concepts of restraint over eating, dietary rules, and importance/dissatisfaction of shape and weight when considering their eating disorder behavior. These items were considered as culturally important concepts and resulted in higher frequency scores when this tool was translated into the Spanish version (Grilo et al., 2012).

Recent research has supported the use of the item “I want to be thinner” in the final tool. Belon, McLaughlin, Smith, Bryan, Witkiesitz, Lash, and Winn (2015) conducted a study measuring invariance of the Eating Disorder Inventory between Caucasian and Hispanic women. Results showed that the subscale of Drive for Thinness showed strong measurement invariance or was able to significantly detect abnormal eating behavior in both Hispanics and Caucasian women (Belon et al., 2015).
Research Question Two

What culturally competent questions and provider behaviors or interactions do Hispanic women endorse as enabling them to volunteer specific information about their eating disorders?

The Hispanic women in this study identified culturally competent questions and provider behaviors or interactions that would enable them to volunteer specific information about their eating disorder. Their feedback generated seven common themes to aid in the development of clinical guidelines on culturally appropriate provider behavior in the primary care setting (Appendix C). These themes are: 1) Show empathy, 2) Avoid being overly analytical, 3) Avoid rushing, 4) Be nonjudgmental, 5) Look at the overall picture, 6) Avoid focusing on weight loss or gain, and, 7) Be willing to sit down with the patient and put down the clipboard/notes.

Specifically, it was important for the women to talk to providers that were not excessively analytical and as a result would diagnose them with other medical conditions rather than looking at the underlying cause- the eating disorder itself. These women also preferred providers that looked at the overall picture. This included looking at signs of eating disorder behavior, in addition to trends on weight, vital signs, and blood results.

The participants in this study wanted providers to ask questions about abnormal eating patterns, rather than focusing on weight loss or gain. For example, one participant wanted the provider to ask her if she felt that she was eating too much or too little. Moreover, the women preferred to keep comments about weight loss or gain off the table because they felt that what the health care provider considered as a positive change, such as weight gain, triggered their eating disorder behavior and resulted in negative thoughts and feelings about themselves. To avoid these triggering actions, several of the participants preferred blind weigh ins. Lastly, another
participant wanted her doctor to make it clear to her that her eating disorder was not about weight changes, rather, her eating disorder was a health issue.

The participants were more prone to discuss their eating disorders with providers who were willing to sit down, not rush, and put down the clipboard or notes. These actions made participants feel that these providers were available and willing to have a conversation with the women about their eating disorders. Moreover, the actions rendered the providers as good listeners. The women in the study also preferred talking to providers that showed empathy and were nonjudgmental. These results were similar to the four-year study of female eating disorder patients conducted by Evans et al. (2011). Additional themes consistent with the study by Evans et al. (2011) but occurring with less frequency included not taking the patient seriously and dismissing the patient. As previously mentioned, this study did not evaluate ethnic minorities and may be considered cross-cultural.

Results on Research Question 2 were consistent with existing literature in identifying helpful provider behaviors. Supportive, empathetic, non-judgmental, and knowledgeable actions were examples of provider behaviors that are considered culturally competent and are useful in detecting eating disorders. Also found to be useful in identifying eating disorders was the provider’s attention to the patient’s dietary rules and feelings on dysmorphic appearance, size and shape of the body.

Items that were discarded occurred with less frequency or had conflicting results. For example, the women felt that direct questions did and did not help them volunteer specific information about their eating disorders. The women that did find direct questions helpful thought that this technique helped them admit to themselves that they did suffer from eating
disorder behavior. Conversely, other participants stated that since they would not admit to themselves that they did have an eating disorder, then the direct approach would not be effective. However, one woman with this belief stated that if the provider asked her directly if she had an eating disorder, but failed to follow up after the question, then this technique would be ineffective. Thus, this may be a good clinical guideline to include if it is associated with provider follow up. In the above-mentioned four-year study by Evan et al. (2011), individuals felt that the direct approach was more helpful in accessing care for eating disorders.

**Relevance of Theoretical Framework**

Overall, the findings of the study did not provide sufficient information to refute or support the theoretical framework informing this study. However, the theoretical framework based on Choi’s *Theory of Cultural Marginality* (2008) was used to develop assessment questions for the RAED and to aide in the development of strategies aimed at preventing, decreasing, and or eliminating eating disorder activity (Choi, 2008). This is possible by recognizing negative response patterns and modifying them to promote health and elicit positive health outcomes.

While all of the items rated above the mean of 2.2 on the 4-point scale, the items developed from the theoretical framework received the lowest average relevance scores by participants. The reasoning for this may be that the other items are already well known to be significant. In comparison, these items were newly developed for the purposes of identifying the stress and/or tension respondents experience as a function of ethnicity and culture and these effects on eating disorders. Nevertheless, greater than half of responses (9 out of 15) were perceived as either somewhat or very relevant. For example, one participant felt that her ethnicity
did not impact her eating disorder because of acculturation and growing up in a predominantly Caucasian neighborhood. However, she did feel isolated from her culture with her eating disorder and her associated dietary restrictions. The participant explained this isolation by stating she could not eat with her family because of the amount of carbohydrates in foods, such as tortillas and rice, common in Hispanic diets. Moreover, she had to avoid foods high in acidity such as tomatoes, lime, lemon, and chile from the health consequences, such as gastritis, from bulimia.

Conversely, another participant felt that her ethnicity did negatively impact her eating disorder. This was more prevalent in the actions of her Hispanic father-in-law, who constantly commented on the woman’s weight fluctuations. The participant stated that her and her therapist discussed that her father-in-law was a very masculine macho, Hispanic husband, who would call out women on their appearance to make himself feel better. Nonetheless, these comments influenced her eating disorder behavior and resulted in food restricting behavior.

Similar to the previous participant, this woman felt like an outsider with her extended family as a result of her preoccupations and restrictions with food. For example, she could not embrace the food within her culture or the traditions of banquet type meals. Since the age of 6 or 7, she has avoided high calorie foods such as tamales, pork meat, and sodas. As a result, she would receive strange looks from her family and was labeled the picky eater.

The feelings of these women resonate with the phenomenon of *cultural marginality* identified within the *Theory of Cultural Marginality*. The first participant felt that she was part of the dominant group or American culture but there was an existing tension with the dietary choices present from her ethnicities’ culture. The second participant also felt isolated with her
dietary choices and was involved in a tension conflict from the norms or expectations as presented by the father-in-law. As a result, the women preferred to eat in isolation and developed social anxiety. The theory of marginality helped identify the isolation present within both women due to dietary restrictions from their eating disorders.

The above-mentioned participants may have experienced acculturative stress, another phenomenon present within the Theory of Cultural Marginality, as they modified their social behavior in response to the different social situations from their Hispanic families. The consequences of discrimination and being different resulting from this phenomenon can produce negative mental health outcomes. A study by Gordon, Castro, Sitnikov, and Holm-Denoma (2010) supports this idea and showed that increased acculturative stress is associated with an increased desire to be thin, among surveyed Latina college students, and is a predictor of symptoms associated with eating disorder behaviors (Gordon et al., 2010). The women in this study felt isolated from their eating disorders within their family context, and as a result, engaged in eating disorder activity by restricting or over eating and purging.

Limitations

The discussion of the findings and interpretation of the data are limited by the small sample size of five individuals. Five individuals are acceptable for focus group interviews, according to Polit and Beck (2008), with topics such as eating disorders because of the associated sensitivity and emotionality. Unfortunately, the participants expressed discomfort in meeting as a group, yet wished to participate in the study, thus multiple individual interviews were conducted. This prohibited data saturation of the items and themes discussed. The decision
to discard certain items was done with caution because of the small sample that does not represent all Hispanic women with eating disorders.

Acculturation of the women within this study was not assessed, however it appears that these individuals may have high acculturation levels which may have affected response scores to these questions and items specific to ethnicity. In previous research, it has been found that Latina women with high levels of acculturation developed attitudes against fat, a norm that is common in the U.S. (Gordon et al., 2010). These attitudes resulted in correlations of concerns with eating and body dissatisfaction, however the high levels of acculturation were not associated with predicting symptoms associated with eating disorders (Gordon et al., 2010). The tool itself is an assessment for eating disorder risk for Hispanic women and may be inhibited in acculturated Hispanic women.

**Implications for Future Research**

Continued research in the future with further testing of a larger sample size would provide additional support on relevance and clarity of items maintained within the tool. Additional research is also needed to determine cut-off scores for clinical significance. For example, is an overall score of 3.0 indicative of an eating disorder?

Continued research would also help clarify provider guidelines that are especially needed in assessing Hispanic women, and those that are applicable across all women. In regards to certain equivocal items, additional research would help determine whether these items were correctly discarded from the final tool and clinical guidelines. Lastly, the larger sample size would help support or refute the use of the theoretical framework informing this study and determine the needed modifications.
Implications for Advanced Nursing Practice: Personal and Disciplinary

Personal Practice. The knowledge obtained through this research has enabled me as an advanced nurse practitioner to use improved communication techniques with my patients who I think may be engaging in aberrant eating behavior activity. That is, patients who exhibit associated symptomology, or have a history of disordered eating, and may benefit from these approaches and techniques. The purpose of using these techniques is to elicit additional health information and create a practice that is focused on the patient, with the possibility of minimizing or avoiding the physical and psychological effects associated with eating disorders. Examples of these communication approaches include use of empathy and being non-judgmental, and in addition to asking the patients directly if they are engaging in aberrant eating behavior and about their diet in general. Results from this study indicate that patients may prefer being asked how often they eat and what sizes and types of meals they consume rather than to focus on their weight. Additional questions include inquiring how patients feel about their body size and overall well-being.

Disciplinary Practice. The currently low detection rates are highly suggestive that it is important for primary care providers, including advanced practice nurses, to have the necessary tools to identify eating disorders in Hispanic women. Advanced practice nurses are willing to screen for eating disorders, however they do need the necessary tools to identify this illness, especially among Hispanic women. Screening tools with treatment protocols can help overcome clinician barriers on what actions to take once the eating disorders are diagnosed. This idea is supported by the fact that only one (20% of the sample) participant’s eating disorder was diagnosed by her primary care provider, despite all these women seeking treatment due to their
symptomology. These women do want help for their eating disorders and need a resource for help. One participant expressed that she had informed her mother of her participation in this study and asked her why she did not “catch it” since they went to the doctor together. The mother replied that she is a less educated person and that if the doctors did not catch her eating disorder, then what makes her think she would have. Primary care providers are educated individuals and this study shows the importance of specifically educating these individuals on techniques to help Hispanic women volunteer specific information about their eating disorder so that they may receive the appropriate treatment.

Knowledge dissemination is also a critical component of scholarly work that supports and advances the discipline, and informs individual practitioners. Dissemination occurs through formal publications and presentations, and informal clinical conferences and interactions with fellow colleagues. The implications of this research emphasize the importance of the role of primary care providers, specifically advanced nurse practitioners, in detecting eating disorders in minority women due to the low detection rates and high prevalence. In my own practice experiences, many Hispanic women present to the clinic for help with weight loss and request diet pills, however I have encouraged my colleagues to consider use of the themes generated in the clinical guidelines to reinforce the caring and patient focused behavior, associated with the profession, thus eliciting more information of eating behavior from the patient. Moreover, I have reinforced the importance of using screening tools to potentially make the challenge of diagnosing eating disorders less of an obstacle. Lastly, the clinic has initiated a journal club to share knowledge among the advanced nurse practitioners. My first shared topic will be on the importance of detecting eating disorders in Hispanic women in the primary care setting and using
techniques to empower these women to volunteer specific information about their disordered behavior so that these women can receive the necessary and appropriate treatment.
APPENDIX A:

RISK ASSESSMENT OF EATING DISORDERS (RAED) TOOL,
PREFERRED PROVIDER BEHAVIORS GUIDELINES QUESTIONNAIRE,
DEMOGRAPHIC AND HEALTH-RELATED QUESTIONNAIRE
Risk Assessment of Eating Disorders (RAED) Tool ©GRCardona2016

Please rate each item below for its relevance (how relevant is it to your experience of having an eating disorder) and for its clarity (how clear or understandable is the item in your judgment). Use the following scales for relevance and clarity and then insert the appropriate number into each box for each item.

To rate Relevance: 1 = Not at all relevant 2 = Mostly not relevant 3 = Somewhat relevant 4 = Very relevant

To rate Clarity: 1 = Not at all clear 2 = Mostly not clear 3 = Somewhat clear 4 = Very clear

<table>
<thead>
<tr>
<th>Risk assessment questions</th>
<th>Rating on relevance (1-4)</th>
<th>Rating on clarity (1-4)</th>
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<tbody>
<tr>
<td>1. Do you make yourself sick because you feel uncomfortably full?</td>
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<tr>
<td>2. Do you worry you have lost control over how much you eat?</td>
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<td>3. Do you believe yourself to be fat when others say you are too thin?</td>
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<td>4. I seek reassurance from others about my appearance.</td>
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<td>5. Have you recently lost more than fourteen pounds in a 3-month period?</td>
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<td>6. Would you say that food dominates your life?</td>
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<td>7. I spend a significant amount of time checking my appearance in the mirror.</td>
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<td>8. I feel others are speaking negatively of my appearance.</td>
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<td>9. I compare my appearance to that of fashion models or others.</td>
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<td>10. I try to camouflage certain flaws in my appearance.</td>
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<td>11. I examine flaws in my appearance.</td>
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<td>12. I have bought clothing to hide a certain aspect of my appearance.</td>
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<td>13. I feel others are more physically attractive than me.</td>
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<td>14. I have missed social activities because of my appearance.</td>
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<td>15. I have been embarrassed to leave the house because of my appearance.</td>
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<td>16. I fear that others will discover my flaws in appearance.</td>
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<tr>
<td>17. I have participated in unhealthy dieting behaviors such as using diet pills to control my weight.</td>
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<td>18. I have skipped meals to control my weight.</td>
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<tr>
<td>19. I do not feel satisfied with the shape of my body.</td>
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<td>20. I am preoccupied with the shape of my body.</td>
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<td>21.</td>
<td>I feel that my stomach is too big.</td>
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<td>22.</td>
<td>I want to be thinner.</td>
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<td>23.</td>
<td>I am preoccupied with food and calories.</td>
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<td>24.</td>
<td>I eat in secret.</td>
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<td>25.</td>
<td>I feel guilty about eating.</td>
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<td>26.</td>
<td>I have a fear of fatness.</td>
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<td>27.</td>
<td>I have discomfort when seeing my body.</td>
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<td>28.</td>
<td>I have feelings of fatness.</td>
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<tr>
<td>29.</td>
<td>I avoid food.</td>
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<td>30.</td>
<td>I feel weight is important.</td>
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<td>31.</td>
<td>I am preoccupied with weight.</td>
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<tr>
<td>32.</td>
<td>I am dissatisfied with my weight.</td>
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<tr>
<td>33.</td>
<td>Do you feel that your ethnicity negatively impacts your eating behaviors?</td>
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<td>34.</td>
<td>I feel I have lost my cultural identity as a result of my preoccupations with food.</td>
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<tr>
<td>35.</td>
<td>I feel that I am isolated from my culture because of my preoccupations with food.</td>
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</table>
Preferred Provider Behaviors Guidelines Questionnaire

1. What types of provider behavior would help you to volunteer specific information about your eating disorder so that these individuals can detect them in the primary care setting? Some examples of behavior include empathy, discussion, understanding, nonjudgmental approaches, direct approach such as just asking if you have an eating disorder, providers who are talkative, providers who provide you with information, providers who are willing to follow up.

2. What types of provider behavior would inhibit you from admitting you have an eating disorder.
Demographic and Health-Related Questionnaire

Demographics
Gender ____________________________________________
Age ________________________________________________
Ethnicity ____________________________________________
Preferred language ____________________________________
Able to read and write in English (yes or no) ______________
Country of origin ______________________________________
Current city of residence ________________________________
What type of eating disorder do you have? ________________
Who diagnosed your eating disorder (i.e., medical doctor, nurse practitioner, psychiatrist)? ________________
How long have you had an eating disorder? ________________
APPENDIX B:

THE UNIVERSITY OF ARIZONA IRB DOCUMENTATION
The University of Arizona Consent to Participate in Research

Study Title: Risk Assessment of Eating Disorders (RAED) in Hispanic Women

Principal Investigator: Genevieve Cardona

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.

Why is this study being done?
The purpose of this study is to collect initial information for the development of a survey on detecting eating disorders in Hispanic women. In addition, information will be collected about behaviors or interactions to enable Hispanic women to “speak up” about their eating disorders. This study involves research and may help clinicians in primary care to overcome cultural barriers in assessing, intervening, and treating eating disorders.

What will happen if I take part in this study?
The study will take place at the Eating Disorders Institute of New Mexico In Rio Rancho. If you choose to be part of this study, you will first fill out a short form on health and demographic information. Next, you will complete a survey rating the relevance and clarity of the newly developed risk assessment of eating disorders survey. Lastly, an audio-recorded group interview will take place discussing provider behavior in assessing Hispanic women with eating disorders, in addition to any modifications recommended for the survey. All information obtained will be used for the research study.

How long will I be in the study?
The total allotted time for the study is 1 hour. Participants are expected to be present for the entire duration.

How many people will take part in this study?
The total number of participants enrolled in the study is 10 individuals.

Can I stop being in the study?
Participation in this survey is voluntary and all individuals may leave the study at any time. There will be no penalties or loss of any of your usual benefits if you refuse to participate. Your decision will not affect your future relationship with The University of Arizona.

What risks, side effects or discomforts can I expect from being in the study?

Protocol 1511207875 Approved by Univ. of Arizona IRB (Expires 25-Nov-2016)
There are minimal risks for participating in this study. Psychological stress may occur since eating disorders is a sensitive topic. Participants who express stress or other concerns about their eating disorders will be referred to their primary care provider or mental health agency of which they are receiving treatment and be provided with an information sheet on distress and safety hotline.

**What benefits can I expect from being in the study?**
There are no direct benefits for participating in the study. However, this study will allow for your voice to be heard in helping with the future detection of eating disorders in Hispanic women.

**What are the costs of taking part in this study?**
There are no costs to taking part of this study except for your personal time and transportation.

**Will I be paid for taking part in this study?**
Participants who complete the study will be given a $25 gift card of their choice to Target or Wal-Mart. Refreshments will be provided during the study.

*By law, payments to subjects may be considered taxable income.*

**What other choices do I have if I do not take part in the study?**
You may choose to not participate in the study. If you would like to participate in the study, but are uncomfortable in a group setting, you may be accommodated with an individual interview on a different date.

**Will my study-related information be kept confidential?**
The responses to this study will be kept confidential. Personal information regarding your participation in this study may be disclosed only if required by state law. However, your records may be reviewed by the following groups:
- Office for Human Research Protections or other federal, state, or international regulatory agencies.
- The University of Arizona Institutional Review Board

**Who can answer my questions about the study?**
For questions, concerns, or complaints about the study you may contact *Genevieve Cardona:*

*email* - gcardona@email.arizona.edu, *phone* - 505-264-3241.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://orcr.arizona.edu/hspp. The investigator for this study, Genevieve Cardona, is a Doctor of Nursing Practice student.

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**Protocol 1511207875 Approved by Univ. of Arizona IRB (Expires 25-Nov-2016)**
The University of Arizona has no insurance for participants should any unforeseen event occur. If you are injured as a result of participating in this study or for questions about a study-related injury, you may contact Genevieve Cardona: email gcardona@email.arizona.edu, phone 505-264-3241.

An Institutional Review Board responsible for human subjects research at The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

**Signing the consent form**

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

<table>
<thead>
<tr>
<th>Printed name of subject</th>
<th>Signature of subject</th>
<th>AM/PM</th>
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</table>

Date and time
AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR RESEARCH

Project Title: Risk Assessment of Eating Disorders (RAED) in Hispanic Women

The United States government has issued a new privacy rule to protect the privacy rights of individuals enrolled in research. The Privacy Rule is designed to protect the confidentiality of an individual’s health information. This document hereafter known as an “Authorization for Use and Disclosure of Protected Health Information for Research” describes your rights and explains how your health information will be used and disclosed for this study.

PURPOSE
You are being invited to participate voluntarily in the above-titled research project. The purpose of collecting Protected Health Information (PHI) for this study is help researchers answer the questions that are being asked in this research study.

WHAT INFORMATION MAY BE USED AND GIVEN TO OTHERS?
Information that will be collected about you includes:
• Gender, age, ethnicity, preferred language, ability to read and write in English, country you were born in, city where you live, type of eating disorder you suffer from, what type of medical provider diagnosed your eating disorder, length of time you have had an eating disorder

WHO MAY USE AND RECEIVE INFORMATION ABOUT ME?
Information about you may be given out by the Principal Investigator and study personnel to:
• Representatives of regulatory agencies (including the University of Arizona Human Subjects Protection Program) to ensure quality of data and study conduct.

WHY WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?
This information will be used to determine if participants meet the requirements to participate in the study and provide data on the population in general.

The results of this research, only in a combined form, may be published in scientific journals or presented at professional meetings, and no identifying information will be in the results.

HOW LONG WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?
Your PHI will be linked to your identifying information for the duration of the study. After this time, all links will be destroyed and your identity will not be able to be determined.

This authorization will expire on the date the research study ends.
MAY I REVIEW OR COPY THE INFORMATION OBTAINED FROM ME OR CREATED ABOUT ME?
You have the right to access your PHI that may be created during this study as it relates to your
treatment or payment. Your access to this information will become available only after the
study analyses are complete.

MAY I WITHDRAW OR REVOKE (CANCEL) MY PERMISSION?
If you do withdraw your authorization, any information previously disclosed will not be used.
You may withdraw this authorization at any time by notifying the Principal Investigator in
writing or any time during the interview process. The address for the Principal Investigator is
6500 Conrad Ave. NW, Albuquerque, NM, 87120.

WHAT IF I DECIDE NOT TO GIVE PERMISSION TO USE AND GIVE OUT MY HEALTH
INFORMATION?
You may refuse to sign this authorization form. If you choose not to sign this form, you cannot
participate in the research study. Refusing to sign will not affect your present or future medical
care and will not cause any loss of benefits to which you are otherwise entitled.

IS MY HEALTH INFORMATION PROTECTED AFTER IT HAS BEEN GIVEN TO OTHERS?
Once information about you is disclosed in accordance with this authorization, the individual or
organization that receives this may redisclose it and your information may no longer be
protected by Federal Privacy Regulations.

CONTACTS
You can obtain further information from the Principal Investigator, (Genevieve Cardona, MSN,
DNP Candidate at (505)-264-3241 and gcardona@email.arizona.edu. If you have questions
concerning your rights as a research subject, you may call the Human Subjects Protection
Program office at (520) 626-6721. If you would like to contact the Human Subjects Protection
Program via the web (this can be anonymous), please visit http://orcr.arizona.edu/hspp

AUTHORIZATION
I hereby authorize the use or disclosure of my individually identifiable health information. I will
be given a copy of this signed authorization form.

Subject’s Signature ________________________________ Date ______________

Printed Name of Subject ________________________________
APPENDIX C:

SHORTENED RISK ASSESSMENT OF EATING DISORDERS (RAED) TOOL AND CLINICAL GUIDELINES FOR PREFERRED PROVIDER BEHAVIORS
Shortened Risk Assessment of Eating Disorders (RAED) in Hispanic Women

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Please rate each item below for its relevance (how relevant is it to your experience). Use the following scale for relevance and then insert the appropriate number into each box for each item.

To rate Relevance: 1 = Not at all relevant 2 = Mostly not relevant 3 = Somewhat relevant 4 = Very relevant

<table>
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<th>Risk assessment questions</th>
<th>Rating on relevance (1-4)</th>
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<tbody>
<tr>
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<tr>
<td>14. I am dissatisfied with my weight.</td>
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</table>
Clinical Guidelines for Preferred Provider Behaviors

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1. Show empathy
2. Avoid being overly analytical
3. Avoid rushing
4. Be nonjudgmental
5. Look at the overall picture
6. Avoid focusing on weight loss or gain
7. Be willing to sit down with the patient and put down the clipboard/notes
APPENDIX D:

FLYERS
Are you a Hispanic female with a diagnosed eating disorder between the ages of 18-45? If so, you may be interested to participate in a 1-hour long focus group developed to improve detection of eating disorders using culturally sensitive techniques. Questionnaire information will also be collected during this meeting. All qualifying participants will be compensated with a $25 gift card from Target or Wal-Mart for their participation.

For additional information please contact Genevieve Cardona, MSN, CNP at gcardona@email.arizona.edu or 505-264-3241.

*The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.
Crisis Hotline & Eating Disorder Assistance

Are you struggling with an eating disorder and scared to ask for help?

If you have an eating disorder there are resources available to help you. Please contact a 24-hour crisis hotline or eating disorder center near you.

• UNM Mental Health (505) 272-2800
• AGORA UNM Crisis Center (505) 277-3013
• Eating Disorders Institute of New Mexico (505) 884-5700
• Eating Disorders Treatment Center, LLC (505) 266-6121
APPENDIX E:

EMAIL INVITATION
Email Invitation

Dear Colleague,

I am a MSN prepared Doctor of Nursing Practice (DNP) Candidate and I am conducting a research study about Hispanic women with eating disorders. The goal of my research is to create a culturally sensitive set of guidelines for clinicians to better assess eating disorders in a way that will help Hispanic women “speak up” about their illness. I am hoping that you will provide my contact information to possible participants so that I may complete this project. I’ve listed the criteria for participants below.

There are many studies addressing the importance of addressing eating disorders in ethnic minorities, however there is lack of studies that look at clinically effective strategies to assess and detect these disorders in a manner that is culturally relevant and clinically feasible. The guidelines will be developed using the feedback from women with eating disorders. I have received Institutional Review Board approval for Human Subjects Research from the University of Arizona.

The following are requirements for the participants to participate in my research study:

1) Women ages 18-45
2) Diagnosis of an eating disorder
3) Female gender
4) Hispanic/Latina American descent and born in the United States
5) English speaking
6) Able to read and write in English

If you have any questions please contact me by email and/or phone, and I am more than happy to answer any questions that you may have. Thank you very much for any help you can provide.

Sincerely,

Genevieve Cardona, MSN, CNP
DNP Candidate
College of Nursing
University of Arizona
Email: gcardona@email.arizona.edu
Cell: 505-264-3241

*The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.
APPENDIX F:

PROVIDER SCRIPT AND REFERRAL FOR PARTICIPATION
Provider Script and Patient Referral for Participation

**Physician/NP/PA/Clinician**: “I would like to let you know that you have the opportunity to participate in a research study if you are interested. Participation means completing a tool and answering questions in a discussion group that a doctoral nursing student from the University of Arizona would like to ask you. She is studying eating disorders in Hispanic women and is interested in improving the detection of these disorders. This study is completely voluntary. Are you interested in learning about the study?”

**If the patient answers yes then say**: “Since you are interested in learning more, I will let her know you are interested. Please write down your contact information on this form and I will ask her to contact you to set up a time where she will provide more information regarding the study. In addition, here is a flyer with her contact information if you would like to contact her.”

**If the patient says no then say**: “Thank you for letting me tell you about this opportunity.”
Referral Form

Client’s Name: ___________________ Date of Referral: ____________
Birthdate: ________________________
Telephone Number: ___________________

Referral To:
Genevieve Cardona, CNP, DNP student
gcardona@email.arizona.edu
505-264-3241

Referred By: [Provider’s name, address, and telephone number]
____________________________________________________________________
____________________________________________________________________

Reason for Referral:
Participation in discussion group for the assessment of eating disorders in Hispanic women.

*The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.
APPENDIX G:

CORRESPONDENCE – EATING DISORDERS INSTITUTE OF NEW MEXICO
September 16, 2015

Office of Nursing Research
University of Arizona and University of Arizona
Human Subjects Protection Program

To whom it may concern:

This letter confirms that Genevieve Cardona, CNP has been granted authorization to recruit study participants for her doctoral research by means of our emailing list of New Mexico healthcare providers. Ms. Cardona is also granted permission to use our physical facility as the location in which to meet with study participants.

If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

[Signature]

Brenda L. Wolfe, Ph.D.
President/CEO
APPENDIX H:

RISK ASSESSMENT OF EATING DISORDERS (RAED) FOCUS GROUP MODERATOR GUIDE
Risk Assessment of Eating Disorders in Hispanic Woman (RAED)
Focus Group Moderator Guide

I. BACKGROUND/INTRODUCTIONS
   a. Introduction and thanks to participants for agreeing to come.
   b. Explanation of activities that will occur during the 1-hour allotted time for the focus group. Specifically, individuals will sign a consent form, then proceed to fill out a health and demographic form and RAED tool. Following the tool will be a discussion group. Participants will be reminded that no last names should be used and that all comments and discussions will be audio-recorded to generate themes in response to the discussion questions. Moreover, things that are said in the room will remain in the room. Reiterate that subjects may withdraw from study at any time if they are uncomfortable or are experiencing stress as a result of focus group.
   c. Signing of consents.
   d. Completion of health and demographic form by participants.

II. TOOL
   a. Explanation of RAED tool.
   b. Completion of RAED tool by participants.

III. DISCUSSION TOPICS
   a. What types of provider behavior would help you to speak up about your eating disorder so that these individuals can detect them in the primary care setting? Prompts include providing some examples of behavior such as showing empathy, taking time to discuss questions, providing information, being nonjudgmental, using a direct approach such as just asking if you have an eating disorder, other behaviors?
   b. What types of provider behavior would inhibit you from admitting you have an eating disorder? Prompts include lack of eye contact, being in a hurry, not asking if you have questions, being judgmental.
   c. Ask for additional suggestions on the RAED items or in general.
   d. Summarize general points identified during the discussion for their validation or correction. Request final comments or feedback.

IV. CLOSING
   a. Provide participants who have completed focus group with gift cards.
   b. Thanks to all participants for their participation.
REFERENCES


