1996

Eating attitudes of Filipino-American women

Josephine Lazaro
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**EATING ATTITUDES OF
FILIPINO-AMERICAN WOMEN**

A Thesis

Presented to

The Faculty of the Department of Occupational Therapy

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Josephine Lazaro

May, 1996

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Abstract

EATING ATTITUDES OF FILIPINO-AMERICAN WOMEN

by Josephine Lazaro

The purpose of this study was to examine the eating attitudes of a sample of Filipino-American women to determine whether they are at risk for developing an eating disorder. Many individuals, particularly women, feel the pressure to conform to society's "thinness ideal."

A questionnaire was distributed to gather information regarding eating attitudes, cultural influences, general Filipino beliefs and attitudes, and treatment-seeking behavior. Descriptive statistics were used to report the results of the study. The limited sample precluded more sophisticated data analysis.

The findings of this study revealed that abnormal eating attitudes and behaviors exist among members of the Filipino-American population. The Filipino-American family was found to play a significant role in the treatment-seeking process and in therapeutic intervention. Occupational therapists have an important role in the promotion and provision of prevention activities for populations that are "at-risk" for eating disorders.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was to determine the eating attitudes of Filipino-American women living in the San Francisco Bay Area. The information was gathered to determine whether Filipino-American women are at risk for developing an eating disorder, anorexia nervosa or bulimia, serious psychophysiological illnesses predominantly occurring in women.

Problem Statement

Extensive research on eating disorders has been conducted over the years. There exists a strong stereotype of the individual with an eating disorder as female, Caucasian, and from a middle to upper class background. This “belief,” according to Thompson (1994), has led to the exclusion of groups of women from various ethnic backgrounds who may have even more complicated reasons for abnormal eating patterns. These reasons include racism, poverty, sexism, and acculturation.

There is limited research and information in the literature involving minorities with eating disorders. A specific deficit in the literature is in understanding the potential development of eating disorders in Filipino-Americans, the second largest Asian group in California according to the 1990 U.S. census (Worsnop, 1991). In the small amount of research involving the Asian population, the existing studies do not include Filipino-

Americans, or will group them with other Asian subgroups such as Chinese or Japanese to form a general Asian group, or will include only a very small number in the sample.

According to Pumariega, Gustavson, Gustavson, Motes, and Ayers (1994), eating disorders are known to pose a major public health problem to women, including non-Caucasian populations, thus it is important to gain knowledge that will help to decrease under identification or misdiagnosis in minority groups who may suffer from these illnesses. It can be inferred that Asians, specifically, Filipino-American women may be “at-risk” for disordered eating as their Caucasian counterparts.

In reviewing the literature, research relating occupational therapy services to Filipino-Americans was not available. However, occupational therapy’s important contribution in all phases of the treatment of eating disorders is well documented (Beck, 1993). The primary areas of occupational therapy involve body image issues, nutrition and food management, social and sexual relationships, communication skills, leisure and work issues, and discharge planning (Beck, 1993). Occupational therapy interventions include providing opportunities for successful experiences, limit setting, reinforcement of behavioral change, art therapy, psychoeducational classes, development of self-care, movement groups, and group and family therapy (Bonder, 1991; Zerbe, 1993).

Research Questions

Research questions to be answered in this study were:

1. What are the eating attitudes of Bay Area Filipino-American women as measured by the Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982)?
-

2. What cultural factors, if any, influence Bay Area Filipino-American women's eating attitudes?
3. What beliefs affect Filipino-American women when deciding whether or not to seek treatment for an eating disorder?
4. Are Filipino-American women an at-risk group for prevention activities by occupational therapists?

Definitions

Definitions generated for this study are:

At-risk: being exposed to a chance of loss, damage, or illness.

Bay Area Filipino-American: an individual of Filipino descent who resides in the San Francisco Bay Area.

Beliefs: one's personal values and norms.

Cultural factors: components of one's environment that influences his or her behavior such as peer pressure, familial interactions, and the media.

Eating attitudes: how one perceives food and eating, especially in relation to his or her body. In this study, these are measured by the Eating Attitudes Test (Garner et al., 1982).

Prevention activities: activities designed to hinder or avert the development of a condition or illness, in this study, meaning activities within the role of occupational therapists.

Assumptions

The assumptions made regarding this study were: accurate assessment of eating attitudes of Filipino-American women would determine if a prevention program for eating

disorders should be implemented by health professionals, including occupational therapists; the subjects were able to understand, read, and write the English language thus the translation of the questionnaire into Filipino dialect(s) was not deemed necessary; and the research subjects would complete the questionnaire accurately, honestly, and anonymously. No separate consent form was given; however, a statement concluded the questionnaire informing the subjects that their voluntary completion of the questionnaire was their consent to be included in the study. They were instructed, both in writing and verbally, not to include their names anywhere on the questionnaire to maintain anonymity.

Limitations

Limitations identified for this study are:

1. Due to the selected, non-randomized, small sample, the findings may not be generalizable to other Filipino-American women. It was the intent of the researcher to secure a more diverse San Francisco Bay Area sample. However, the sample consisted San Jose State students, many of whom reside in the San Francisco Bay Area.
2. Reliability testing for the portion of the questionnaire that addresses the cultural values of this population has not been conducted.
3. Some participants may have preferred to select from a list of given responses rather than select the option of “other” which required writing an explanation, thus not reflecting their true responses.
4. Questionnaire items regarding weight, which may seem personal, may result in inaccurate reporting by some participants who may feel ashamed or uncomfortable with

their current weight.

5. Since the sample was from a college population, the ages were limited from 18 to 24 years.

Significance of the Study

Filipino-Americans make up one of the largest Asian groups in the San Francisco Bay Area. The potential for developing abnormal eating attitudes and eating disorders is quite strong when living in the Western culture where there is a “drive for thinness.” The literature reports that women from ethnic groups are also at risk of developing these problems (Dolan, 1991). The determination whether eating disorders are a significant health risk to Filipino-American women has not yet been made. This study will gather data to reveal whether this is an “at-risk” population for which prevention efforts are necessary. Occupational therapists have the skills and knowledge to address some of the underlying factors of eating disorders. Rather than simply intervening during the progression of the illness, if indicated, occupational therapists can take an active role in health promotion and prevention of eating disorders.

CHAPTER 2

LITERATURE REVIEW

The literature review covers background information on culture and health care, Filipino-Americans' health and illness beliefs, and eating disorders. Theoretical models of eating disorders, cultural influences, and the eating attitudes of Caucasian and various ethnic groups are explored. Theoretical concepts of occupational therapy, and the focus on wellness, health promotion, and disease prevention are described.

Culture and Health Care

Considering the growing number of ethnic groups in America, it is important for health care professionals to be culturally aware. Occupational therapy focuses on holism, in essence, treating the whole person. This would not only involve the consideration of physical, mental, and emotional aspects, but cultural background as well.

Cultural competence is the awareness of, sensitivity to, and knowledge of the meaning of culture. This involves the willingness of the health care provider to learn about cultural issues and an awareness of one's cultural biases. Cultural competence is a lifelong process and is necessary to provide quality services (Dillard, Andonian, Flores, Lai, MacRae, & Shakir, 1992). It is important to state that the health professional should treat each client, from any ethnic group, as an individual who has the unique blend of many influences and experiences (McAvoy & Donaldson, 1990).

According to Pope-Davis, Prieto, Whitaker, and Pope-Davis (1993), appropriate provision of services can only occur when the following are considered: cultural diversity

of patients, the interaction of patient culture with the culture of the health professional, and the orientation of the western medical model. They further describe multicultural competencies as consisting of beliefs and attitudes, knowledge, skills, and relationships. Beliefs and attitudes involve the awareness of one's cultural values and biases, and how these affect his or her relations with persons of different ethnicity. Knowledge refers to the ability to respect differences of other cultural groups and to understand some of their experiences in society as members of an ethnic group. Skills are the behaviors demonstrated during interaction with patients from different cultural backgrounds. Culturally skilled individuals are sensitive to cultural-specific behaviors of their client and demonstrate behaviors and techniques appropriate to the patient's cultural context. The fourth component, relationship, is the integration of knowledge, beliefs and attitudes, and skills. These contribute to the development of positive and therapeutic relationships with patients from different cultural groups (Pope-Davis et al., 1993).

Filipino-Americans' Health and Illness Beliefs

The most central indigenous Filipino-American health concept is that of balance. Health symbolizes balance, and illness is the result of imbalance. There exists a range of "hot"- "cold" beliefs involving the balances in the body, and food and dietary practices. Optimal health is maintained in part by maintaining a "warm" condition. Being a little stout and especially keeping baby fat are preferred to being too thin for added "protection" or as a reserve in one's strength (Anderson, 1983).

Anderson (1983) further stated that Filipino-Americans often do not seek medical

treatment for an illness until it has progressed and the patient is suffering severe pain. At the onset of illness, patients usually rely on home remedies. One sees a healer or physician only after all home remedies have been tried or when the pain becomes unbearable (Montepio, 1986). They often explain their delay in responding to symptoms of ill health by stating that they were trying to identify the illness' characteristics, possible cause, severity, and chronicity (Anderson, 1983).

In traditional Asian families, there is considerable emphasis upon bringing honor to the family name and maintaining a good reputation. An individual's action reflects upon the entire family. Behaviors that carry a negative connotation such as delinquency, academic failure, or mental illness may bring shame, disgrace, and dishonor to the family name. A result of this is the family system which exerts great pressures to keep such problems hidden from the public, and thus may result in low usage of clinical services. This supports the finding of mental health professionals that Asian Americans as a group underutilize traditional mental health services (Sue, 1994).

In the Filipino medical system, diseases are conceptualized as either natural or supernatural in origin. Both are often held responsible, particularly in debilitating illnesses. There is emphasis on multi-causal explanations rather than the one-cause/one-effect pattern commonly found in the Western medical system (Montepio, 1986). Some natural forces that are believed to adversely affect health are overwork, overexposure to natural elements, overeating, lack of nutrition, lack of sleep, unsanitary environment, excessive worry, and imbalance of hot and cold elements. Supernatural ailments result from the

displeasure of environmental spirits, souls of the dead, evil persons, or from punishment for the transgression against God, fellow human beings, or nature (Montepio, 1986).

Asians experience illness and death as part of the normal life cycle. Life is characterized by birth, old age, sickness, and death. Many Asians believe that illness or other unfortunate occurrence in life is the result of bad luck or a bad deed committed from the previous life. Ideally, death and illness should be faced with calmness and stoicism. However, it is difficult to achieve this ideal and thus the patient will most likely experience helplessness, denial, and depression (Nilchaikovit, Hill, & Holland, 1993).

Role of the Asian Family in Illness

In Asian cultures, when a person is ill, there is more “permission” for regression and dependence than in Western cultures (Nilchaikovit et al., 1993). It is generally acceptable to be dependent and the patient may even feel entitled to be cared for. Nilchaikovit et al. further stated that Asians view illness as a family problem rather than an individual problem due to the predominant familiistic orientation of their culture. At times, the Asian family may seem to be overinvolved in the process. The role of the family is extremely important to the patient, particularly when it comes to making decisions such as when and where to seek treatment. The deep sense of obligation to the family can be used as a motivating factor for therapeutic purposes. In general, the family’s involvement significantly enhances patient compliance.

The role of the Asian family in illness can not be overemphasized. When caring for the patient, family members will take turns being the caregiver so that the patient will be

cared for during all hours of the day. The family cares for the patient in a way that may seem “infantilizing” in the American culture. An example is spoon-feeding the patient even though he or she is capable of self-feeding (Nilchaikovit et al., 1993).

Physician-Patient Relationship

In Asian cultures, the ideal physician-patient relationship is characterized by an emotional connectedness and interdependence with expectations of reciprocity. There is sensitivity to one's feelings and needs without verbally expressing them. Physicians are seen as authority figures who are knowledgeable, experienced, and wise. Physicians are expected to be virtuous, concerned, and responsible for the patient's welfare. The patient is expected to show respect for the physician's suggestions and appreciate his or her assistance. However, when expectations are not fulfilled, the patient may become upset and may not verbally express these feelings. This may result in a passive-aggressive mode of reaction such as noncompliance, premature termination of treatment, or the search for a new physician (Nilchaikovit et al., 1993).

Eating Disorders

Eating disorders are important as a cultural phenomenon in the health of women in Western society. The endorsement that society gives to an ideal of thinness for women is likely to be responsible for the current high frequency of these disorders, particularly anorexia nervosa and bulimia. According to Pate, Pumariega, Hester, and Garner (1992), eating disorders are unique because they appear to be the only form of psychopathology in which culture appears to play a significant role in determining prevalence. Once believed

to be illnesses in the Caucasian, upper-middle class, it appears that the prevalence of these disorders may be increasing among all social classes and ethnic groups in the United States and other countries (Dolan, 1991).

Theoretical Models of Eating Disorders

Theoretical models that explain the epidemiology, etiology, and treatment of eating disorders are the biomedical, psychological, and sociocultural models. The biomedical model offers scientific research about possible physiological causes of eating disorders and the dangers of purging and starvation. The illness is accompanied by physiological abnormalities such as hypothermia, edema, hypotension, bradycardia, and lanugo or soft, downlike hair (Brumberg, 1988). The psychological model identifies eating disorders as multidimensional disorders that are influenced by biological, psychological, and cultural factors (Thompson, 1994). A sense of ineffectiveness results in controlling one's body, something that no one else can control. The sociocultural model implicates society's emphasis on dieting and slimness as central standards of beauty (Banks, 1992). The numerous types of advertisements for fitness programs and diet foods demonstrate the pressure for thinness.

Anorexia Nervosa and Bulimia

Anorexia nervosa is popularly known as the self-starvation disease. The clinical features are refusal to maintain body weight at or above a minimally normal weight for age and height; intense fear of gaining weight even though underweight; disturbance in the way one's body weight or shape is experienced; and absence of at least three consecutive

menstrual cycles in post-menarchal women (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed.).

Bulimia is popularly known as the binge-purge syndrome. The clinical features are recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time); a feeling of lack of control over eating behavior during eating binges; recurrent inappropriate compensatory behavior such as self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise to prevent weight gain; minimum average of two binge eating episodes per week for three months; self-evaluation is influenced by body shape and weight; and the disturbance does not occur exclusively in Anorexia Nervosa. Bulimia is the most common eating disorder having a prevalence of 15-30%. The onset is during adolescence or early adulthood (DSM-IV, 1994).

Perfectionism/Control

The pre-illness personality of persons with anorexia nervosa is characterized by perfectionism and perseverance and not much insight into the abnormality of their eating habits. They are considered to be model children who are well behaved and high achievers academically (Beck, 1993). There is also a need to conform. Many have experienced feeling unable to control their lives and dieting provides them with an opportunity to assert their independence (Touyz & Beumont, 1985).

Refusal of food is interpreted as an expression of the adolescent's struggle over autonomy, individuation, and sexual development. Due to the sense of ineffectiveness and

anxiety about one's identity, the individual opts to control her body. The preoccupation of controlling one's appetite directs the person inward and thus increasing separation from the real world (Brumberg, 1988).

There is a focus that intrafamilial conflict, particularly high parental control, may play a role in eating disturbance. Certain types of family environments encourage passive methods of defiance, such as refusal to eat. This is a form of overcontrol that subtly represents hostility and rebellion (Brumberg, 1988). A study conducted by Ahmad, Waller, and Verduyn (1994) revealed that Asian females rated both their parents as overprotective and their mothers more controlling than their fathers. The Asian females scored higher on the Eating Attitudes Test than the Caucasian females indicating a higher risk for developing an eating disorder. Bryant-Waugh and Lask (1991) have focused on this intrafamilial conflict in females of Asian origin who live in Western society. The conflict is seen as a result of the individual being caught between the two processes of feeling controlled by the family, and trying to emulate the independence of non-Asian peers. The person tries to establish some "internal" control which is not accessible to the family. This control is via self-starvation.

Cultural Influences

Culture is an anthropological term, defining a complex whole that includes knowledge, behavior, morals, customs, and often religion. Culture is acquired by being and/or growing up as a member of a society or a social group. It is arbitrary and variable, as are the value systems derived from it (Dolan, 1991).

Some of the sociocultural factors that put women at risk for eating disorders are (a) the value placed on a thin physique, (b) the norm of dieting, (c) the value of perfection, (d) the media's influence on these values, norms, and standards, and (e) the choice of certain professions (White, 1992).

In Western culture, the ideal of thinness symbolizes self-discipline, control, sexual liberation, assertiveness, competitiveness, affiliation with a higher socioeconomic class, and attractiveness (Pate et al., 1992). The historical shift from the rounded body preference to the "waif" of the 1990's is an example of the change in Western values towards thinness. Dieting is a widely practiced and admired form of cultural expression (Brumberg, 1988). Dieting can be related to different conditioning processes that may predispose a person to binge eating such as increasing the appeal of "forbidden" or "binge" foods (those high in fat and sugar). The issue of whether or not dieting causes an eating disorder is controversial (Wilson, 1993). According to White (1992), the pursuit of perfection drives women, as a gender, to be more concerned with their body image and physical appearance in a society that stresses perfection.

The mass media plays a significant role in reinforcing the pressure to be thin. Women in the Western cultures are constantly bombarded on a daily basis to be slim by television, magazines, and consumer products. As the media appear to be able to influence people's thoughts and self concepts, their role in promoting obsession with weight, chronic dieting, and eating disorders among women deserves pressure for change (Silverstein, Perdue, Peterson, & Kelly, 1986). A study conducted by Garner, Garfinkel,

Schwartz, and Thompson (1980) reviewed weight and height data from Miss America contestants and Playboy magazine centerfolds between 1960 and 1979. They found a decrease in the weight of candidates over the 20-year period, supporting society's demand for thinness. Also, during the same period, there was an increase in the number of diet articles which appeared in popular women's magazines.

A study conducted by Silverstein et al. (1986) entailed a content analysis (relating to weight messages) of the most popular women's and men's magazines. They focused on advertisements and articles that dealt with body shape and size, dieting, and food. The results of the study supported the hypothesis that women receive significantly more messages to be slim and stay in shape than do men (96:12). Also, women receive more messages about eating than do men (63:1), except in the advertisements for alcoholic beverages. Silverstein et al. further stated that the standard of thinness may not necessarily originate in the media, but the enormous popularity of media makes it one of the most influential promoters of thinness.

Professionals that promote personal appearance and weight standards, such as dancers (ballet, gymnastic), athletes, actors, and fashion models are risk factors. There is evidence that suggests that the incidence of eating pathology among these individuals is greater than those persons whose professions do not focus on personal appearance (White, 1992).

Eating Attitudes and Knowledge of Eating Disorders of Caucasian Groups

A general finding of studies of people's knowledge about eating disorders reveal

that they are more aware of anorexia nervosa than bulimia which may be due to the media's greater emphasis on anorexia nervosa. A study conducted by Murray, Touyz, and Beumont (1988), revealed almost all subjects (99% of females and 97% of males) had heard of anorexia nervosa. There was a greater ignorance of bulimia. Also, there was a significant sex difference in knowledge with females being more informed about eating disorders.

Smith, Pruitt, Mann, and Thelen (1986) administered a questionnaire to 313 college and 278 high school students to determine their knowledge of eating disorders and their attitudes toward individuals who suffered from these disorders. The overall distribution by sex was 46.6% male and 53.4% female. The results revealed that more females than males at both high school and college levels were able to define bulimia and anorexia nervosa, as well as to identify most of the factors listed as causes (emotional problems, influence of friends and media) of eating disorders. Subjects' attitudes toward females with eating problems were examined. The individuals who were most rejected as a "friend" were the female of average weight who vomits to control weight (15%), the extremely thin female on a diet (15%), the overweight female (11%), and the female of average weight who binge eats (10%). The sample size is large with almost half of the respondents enrolled in introductory psychology courses, thus their responses would naturally reflect their knowledge of eating disorders. The data gathered may not be generalized to other student populations who are not enrolled in psychology courses, thus having less knowledge of eating disorders.

Eating Attitudes of Ethnic Groups

There has been a recent increase in awareness of eating problems among non-Caucasian populations. Epidemiological studies, case studies, clinical reports, and surveys have demonstrated that levels of eating psychopathology differ across ethnic groups (Ahmad et al., 1994). A review of the literature revealed that no studies surveying the eating attitudes of Filipino-American women have been conducted. However, there were studies that included Asian women as one general group, but did not include a significant number of Filipino-American women, if at all.

Dolan (1991) reported findings from a study that surveyed 204 Asian and 355 Caucasian schoolgirls in England. The Eating Attitudes Test (EAT) designed by Garner et al. (1982) and the Body Shape Questionnaire (BSQ) developed by Cooper, Charnock, & Taylor (1987) were administered. Results did not reveal any differences in the BSQ scores for both groups. However, the mean EAT score of the Asian girls was significantly higher than the Caucasian group. This indicates that the Asian girls may have a higher risk of developing an eating disorder.

Pumariega et al. (1994) conducted the largest eating disorders study of African-American females to date. A questionnaire was placed in Essence magazine, the largest African-American women's publication in the United States. There were 2,161 responses to the survey. A stratified and randomly selected subsample of 600 was analyzed in depth. The respondents were between the ages of 17-62, with a mean age of 31. The survey questionnaire consisted of the Eating Attitudes Test (EAT), the Body Image Distortion

and Dissatisfaction Evaluation (BIDDE), and supplementary items. In the BIDDE, respondents are presented with a standard silhouette that serves as a stimulus image. The respondents are asked to re-form the outline twice: first to look like them currently, and then to how they would like to look. Supplementary items relating to laxative abuse and depression were added. Studies have shown that African-Americans prefer laxatives over purging for weight control (Dolan, 1991). An item relating to the strength of African-American identity was added to examine the relationship of abnormal eating attitudes and the degree of African-American cultural identification. The results revealed that 53.5% of the respondents were at risk for an eating disorder either anorexia nervosa or bulimia. There was a higher frequency of laxative use (16.5%) versus self-induced vomiting (3.5%). The results of the BIDDE showed that only 3% of the respondents saw themselves as underweight, 47.5% saw themselves as average in stature, and 49.5% viewed themselves as overweight, indicating that almost half of the respondents overdistorted their body image perception. Some respondents enclosed letters that expressed the cultural pressures they felt to conform to the thinness ideal of Western society. However, these data may not be generalizable since these attitudes may not reflect the beliefs of African-American females who do not subscribe to this particular magazine, thus not able to participate. Also, the study did not have a random sample since those who responded most likely were biased to this topic of eating attitudes and disorders.

Another study involving ethnic groups was conducted by Smith and Krejci (1991). They administered the Eating Disorder Inventory and the Bulimia Test to high school

adolescents in New Mexico. There were 327 Hispanic, 129 Native American, and 89 Caucasian participants. Native Americans consistently scored the highest on items representing disturbed eating behaviors and attitudes. The results presenting the greatest concern were those relating to fear of weight gain and body dissatisfaction. According to Pate et al. (1992), this may be due to the rejection of the image of the traditional woman on the reservation. The Native American participants (56.6%), were more likely to binge and 40% of them were fasting or excessively dieting. The limitations of this study are the small sample of Caucasian students (89), and the possibility that those students who chose to participate were different or biased from those who did not choose to participate. Also, supplementary items should have been added to address any cultural-specific norms or beliefs, if any, regarding eating in each ethnic group.

Conceptual Framework/Theoretical Concepts for Occupational Therapy

Health Promotion/Disease Prevention

The growing belief among health professionals is that further improvements in the health of people will be achieved through a commitment to efforts designed to prevent disease and to promote health. The concept of health promotion and wellness is based on a philosophy of holism. This consists of a belief in the interaction of the mind, body, spirit, and environment; the oneness of entities; the concept of balance and harmony; and individual responsibility (White, 1986). Prevention seeks to protect an individual from a harmful threat such as an illness or disease.

The American Occupational Therapy Association (1989) adopted an official

position on the promotion of health and the prevention of disease and disability. It states that health promotion and wellness is the basis of prevention efforts and should be a significant part of therapeutic intervention. West (1969) emphasized the growing importance of prevention and the role of occupational therapy in this arena. Prevention is the first component of the health and medical care continuum. The spectrum of prevention is divided into two stages. Stage One, or primary prevention, includes activities designed to prevent the occurrence of illness and disability. An example of this would be occupational therapists providing direct education about eating disorders to populations at risk for developing them. Educating these groups may help to change unhealthy thinking patterns. According to Johnson (1986), the psychosocial and occupational behavior knowledge and skills of the occupational therapist, supplemented by additional knowledge, can be valuable in reviewing health habits, coping skills, and in undertaking behavioral changes. Stage Two, or secondary prevention, includes activities focused at early detection of disease, deficit, deviation, dysfunction, and disability. An example is the occupational therapist preventing further deterioration or regression resulting from self-starvation. This is followed by tertiary prevention which is intervention to prevent or retard progression to more serious conditions (West, 1969).

In the past and present, engagement in prevention has been limited due to skeptical attitudes of medical and health professionals, insurance companies, inadequate research methodologies, and the lack of access to environments aimed at prevention (Johnson, 1986). West (1969) further stressed the need for increased emphasis on occupational

therapists' roles as evaluators, programmers, consultants, and supervisors along with their traditional roles as therapists, thus a shift from the institution to the community. According to Levy (1993), the health promotion and disease prevention movement is based on the recognition that the most useful solutions to the most prominent health problems are prevention and control of the progression of these illnesses.

Model of Human Occupation

The model of human occupation by Kielhofner (1980) will guide this study. According to this model, the individual is seen as an open system interacting with the environment. The environment includes external objects, people, and events that influence the system's action. The environmental influences related to eating disorders include family, peers, and society. The interaction of input, throughput, output, and feedback creates a cycle which makes the system self-transforming. New information can modify the person. According to Donaldson (1986), the person with anorexia nervosa is resistant to change and thus the ability to receive information from the environment is limited. The pursuit of thinness is the individual's way of having control in his or her life while hindering the learning of age-appropriate skills to deal effectively with the challenges of adulthood.

The concept of benign and vicious cycles, a paper for the model of human occupation, is relevant to this study. These are cycles of interaction between the system and the environment which can either result in adaptation or maladaptation. A benign cycle is characterized by the individual feeling a sense of competence that leads to a sense

of efficacy. Adaptation requires the individual to meet the internal urge to explore, master, and fulfill demands of the environment. Vicious cycles are characterized by the individual's feelings of incompetence and loss of opportunities to acquire new skills. Dissatisfaction in either the system or environment further describes the vicious cycle. The person who has an eating disorder feels incompetent and unable to meet the demands of the environment. He or she turns to abnormal eating patterns to maintain control while limiting his or her abilities to physically, mentally, emotionally, and socially mature. As the illness persists, this sense of control is lost and the individual becomes more obsessed with weight and dieting, thus perpetuating the vicious cycle.

Kielhofner (1995) further describes a general therapeutic principle which can be applied to this study. This principle states that the only tool for occupational therapists to affect change in the human system is to change some aspect of the person's relevant environment. The change in one's environment will propel change in the individual that would hopefully lead to adaptation and reverse the vicious cycle to a benign cycle. The result would be satisfaction and competence.

Summary

The available literature has shown evidence that abnormal eating attitudes and behaviors exist in ethnic populations. Western society's ideal of thinness and perfection, encompassed with role conflicts, media influences, and other personal stresses has led to women's development of eating disorders. Occupational therapists have a role in the prevention of abnormal eating attitudes and eating disorders. They can provide direct

education to populations who have a potential to develop these problems. The potential risk of abnormal eating patterns in women of all ethnic groups, particularly in the Western culture, supports the idea for the need of a health promotion and disease prevention program.

CHAPTER 3

RESEARCH PROCEDURES/METHODOLOGY

The purpose of this study was to determine the eating attitudes of Filipino-American women who live in the San Francisco Bay Area. The information was gathered to determine whether Filipino-American women are at risk for developing an eating disorder, anorexia nervosa or bulimia, serious psychophysiological illnesses predominantly occurring in women.

Research Questions

Research questions to be answered in this study were:

1. What are the eating attitudes of Bay Area Filipino-American women as measured by the Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982)?
2. What cultural factors, if any, influence Bay Area Filipino-American women's eating attitudes?
3. What beliefs affect Filipino-American women when deciding whether or not to seek treatment for an eating disorder?
4. Are Filipino-American women an at-risk group for prevention activities by occupational therapists?

Subjects

Subjects for this study were Filipino-American women who were members of Akbayan, the Filipino student association at San Jose State University. The

non-randomized sample consisted of subjects who participated in Akbayan's annual Cultural Night performance.

Instrument

The instrument used in this study is the Eating Attitudes Test-26 (EAT-26) designed by Garner et al. (1982), with questions added to gather demographic information, degree of ethnic identity, parental control, cultural influences, dieting and health-seeking behavior (see Appendix A). There was a total of 49 items on the questionnaire. The format included forced-choice and open-ended questions. Some of the questions had the option of "other" with space provided for an explanation.

The Eating Attitudes Test-26 consists of 26 forced-choice items in three subscales: dieting, bulimia and food preoccupation, and oral control. Respondents must rate each item as "always," "usually," "often," "sometimes," "rarely," or "never." The EAT-26 is widely used in many countries other than the United States.

Open-ended questions were included to address specific Filipino beliefs that may influence the subjects' behavior and attitudes, in general; and to gather comments regarding personal experiences with eating and weight.

The Eating Attitudes Test has been validated with anorexia nervosa patients and has also been useful in identifying eating disturbances in non-clinical samples. Though most individuals from non-clinical samples who achieve a high score on the Eating Attitudes Test do not meet the diagnostic criteria for anorexia nervosa, some have experienced abnormal eating patterns that may interfere with their functioning. A

limitation of the Eating Attitudes Test is that it does not reveal the motivation or psychopathology for behaviors. This test is suitable as a screening instrument in non-clinical settings or as an outcome measure in clinical groups (Garner et al., 1982).

Procedure

The data were collected backstage at Cultural Night, Akbayan's annual celebration and public performance. The president of the organization introduced the researcher to the members and the researcher proceeded to describe the study (see Appendix B). The instrument was distributed with a cover letter that described the study and requested participation in the study (see Appendix C). The questionnaires were collected by the researcher at various times throughout the evening. The participants completed the questionnaires either in between or after their scheduled performances and returned them to the researcher upon completion. The researcher was available throughout the questionnaire administration to address any questions or comments from the participants regarding the questionnaire or the study.

Data Analysis

Because the number of participants was limited to 27, descriptive statistics were used to analyze the data. The portion of the questionnaire with the Eating Attitudes Test-26 was scored according to the published guidelines. Responses for each item were weighted from zero to 3, with a score of 3 assigned to responses farthest in the "symptomatic" direction ("always"); a score of 2 for the immediately adjacent response ("usually"); a score of 1 for the next adjacent response ("often"); and zero assigned to the

three responses farthest in the “asymptomatic” direction (“sometimes,” “rarely,” and “never”). The total EAT-26 score is the sum of all 26 items (Garner et al., 1982). A total score of 20 and above indicates a risk for developing an eating disorder.

CHAPTER FOUR

DATA AND RESULTS

The results of this study are based on the responses to a questionnaire designed to examine the eating attitudes of Filipino-American women in the San Francisco Bay Area. Incomplete items on the questionnaire were not included in the data analysis for that particular question. Demographic information will be reported first and the results are reported in the order presented on the questionnaire. Research questions are addressed at the end of the chapter.

Demographic Data

Age

Twenty seven female subjects participated in the study. Their ages ranged from 18 to 24 years. The mean age for this group was 20.8 years.

Education

The participants were students at San Jose State University and were members of Akbayan, the Filipino Student Association on campus.

Foreign Versus American-Born

Seventeen (63%) of the participants were born in the United States while 10 (37%) were foreign born. The lengths of stay of participants who were foreign born varied from 10 years, as claimed by four respondents; 17 years, as claimed by two respondents; and 19 years, as reported by three respondents. One participant did not indicate the number of years she has resided in the United States.

Eating Attitudes Test Data

The Eating Attitudes Test (EAT) comprised the first portion of the questionnaire. Participants were asked to complete 26 forced-choice items to best reflect their behaviors and attitudes.

The Eating Attitudes Test scores from this sample of Filipino-American women were widely dispersed ranging from 1 to 33, indicating virtually no risk to high risk, respectively, for developing an eating disorder. The ranges of scores were: from 1-5 ($n = 10$, 37%); from 6-10 ($n = 7$, 26%); from 11-15 ($n = 2$, 8%); from 16-20 ($n = 3$, 12%); and 21 and above ($n = 5$, 19%) (see Table 1). Using the established cut-off score for the Eating Attitudes Test, which is 20, five (19%) of the participants were considered to be at risk for developing an eating disorder as reflected by their scores ranging from 22-33.

The Eating Attitudes Test items were placed in the established subscales of dieting, bulimia and food preoccupation, and oral control. Only the data for items that were analyzed symptomatically are reported.

The dieting subscale items that were analyzed symptomatically by at least 25% of the participants were as follows: 65% of the participants were terrified of being overweight; 57% exercise to burn calories; 38% expressed preoccupation with the desire to be thinner; 35% were aware of the calorie content in food; 30% were preoccupied with the thought of having fat on their body; and 27% eat diet foods (see Table 2).

The bulimia and food preoccupation subscale revealed 23% ($n = 6$) of the participants were preoccupied with food and 28% ($n = 7$) give too much time and thought

Table 1**Eating Attitudes Test-26 (EAT-26) Scores (N = 27)**

EAT Score	Frequency	Percentage
1	2	8
3	3	12
4	3	12
5	2	8
6	1	4
7	1	4
8	4	15
9	1	4
11	1	4
12	1	4
16	1	4
17	1	4
18	1	4
22	1	4
24	1	4
26	1	4

(table continues)

EAT Score	Frequency	Percentage
28	1	4
33	1	4

Table 2**Dieting Subscale for Eating Attitudes Test-26 (N=27)**

EAT Item	“always”	“usually”	“often”	Total
Terrified of being overweight	41%	12%	12%	65%
Aware of calorie content in food	12%	15%	8%	35%
Avoid high carbohydrate foods	0%	8%	0%	8%
Guilty after eating	8%	4%	0%	12%
Preoccupied with desire to be thinner	8%	15%	15%	38%
Exercise to burn calories	19%	19%	19%	57%
Preoccupied with fat on body	15%	15%	0%	30%
Avoid foods with sugar in them	0%	4%	8%	12%
Eat diet foods	0%	12%	15%	27%
Uncomfortable eating sweets	0%	12%	0%	12%
Engage in dieting behavior	0%	12%	4%	16%
Like my stomach empty	0%	8%	0%	8%

to food. Only one (4%) participant responded positively for the items related to uncontrollable eating binges and vomiting after eating. Two (8%) women indicated that food controls their lives (see Table 3).

The oral control subscale further revealed abnormal attitudes and behaviors. The findings were: 32% of the participants cut food into small pieces; 31% display self-control around food; 24% feel others think they are too thin; 24% take longer than others to eat meals; 20% express that others prefer that they eat more; 12% avoid eating when hungry; and 12% are pressured by others to eat (see Table 4).

Supplemental Items

Two supplemental items were included at the end of the Eating Attitudes Test to address parental expectations of excellence and achievement orientation. A large percentage of the participants ($n = 22$, 82%) indicated that their parents have “often,” “usually,” or “always” expected excellence from them. For achievement orientation, 24 (89%) of the participants indicated having extremely high goals.

Satisfaction/Dissatisfaction with Weight

The heights of the participants ranged from 4 feet 11 inches to 5 feet 7 inches and their weights ranged from 97 to 250 pounds. Participants were asked about satisfaction or dissatisfaction with their current weight as well as their preferred weight. The majority of the women seemed to be average or below average in weight in relation to their height. Ten (37%) women indicated satisfaction with their current weight, 16 (60%) expressed dissatisfaction, and one did not indicate either (see Table 5). For those who expressed

Table 3**Bulimia and Food Preoccupation Subscale for Eating Attitudes Test-26 (N=27)**

EAT Item	“always”	“usually”	“often”	Total
Preoccupied with food	0%	15%	8%	23%
Eating binges I can not stop	0%	0%	4%	4%
Vomit after eating	0%	0%	4%	4%
Food controls my life	4%	4%	0%	8%
Give too much time and thought to food	4%	12%	12%	28%
Have the impulse to vomit after meals	0%	0%	0%	0%

Table 4**Oral Control Subscale for Eating Attitudes Test-26 (N=27)**

EAT Item	“always”	“usually”	“often”	Total
Avoid eating when hungry	0%	4%	8%	12%
Cut food into small pieces	8%	12%	12%	32%
Others prefer that I eat more	4%	16%	0%	20%
Others think I am too thin	0%	12%	12%	24%
Take longer than others to eat meals	12%	8%	4%	24%
Display self control around food	4%	12%	15%	31%
Others pressure me to eat	8%	0%	4%	12%

Table 5**Satisfaction/Dissatisfaction With Current Weight (N = 27)**

	Frequency	Percentage
Satisfied	10	37
Dissatisfied	16	60
prefer to gain weight	4	15
prefer to lose weight	12	45
Not specified	1	4

dissatisfaction, 4 (15%) participants would like to gain at least 5 pounds and 12 (45%) want to lose weight. The desired weight loss varied from 5 pounds up to 100 pounds as reported by one woman who weighed over 200 pounds. Ten (37%) of the women would like to lose at least 10 pounds. Some participants who were similar in height and weight expressed different levels of satisfaction regarding their current weight. For example, one woman who was 5 feet 6 inches tall and weighed 120 pounds expressed she would like to be 110 pounds while another participant, who was the same height and weight, indicated satisfaction with her current weight. Another participant at 5 feet 2 inches in height and weighing 120 pounds preferred to lose 20 pounds while another woman who was shorter, 4 feet 11 inches and also 120 pounds was content with her current weight.

Dieting Behavior

Participants responded to questions related to their dieting behavior from a list of five options. This list was administered along with the selection of “other” to allow for a write-in response. For this particular question, participants were instructed to check all that applied to them. Reasons selected for their dieting were: to look better ($n = 15$, 56%), to lose weight ($n = 14$, 52%), to feel better ($n = 12$, 45%), pressure from family ($n = 2$, 8%), and pressure from friends ($n = 1$, 4%). The option of “other” ($n = 3$, 12%) was selected to include the opposite sex and one’s overall health as additional reasons for dieting.

Participants were asked to describe their families’ reactions to their dieting behavior given a list of five options including “other.” They were instructed to select only

one response. The descriptions selected were: supportive ($n = 10$, 42%), discouraging ($n = 6$, 25%), unaware of participant's dieting ($n = 5$, 21%), and disinterested ($n = 3$, 13%). The option of "other" was not selected by any of the participants.

Treatment-Seeking Behavior

None of the participants in this sample reported having received treatment for an eating disorder, anorexia nervosa or bulimia. When asked if they would seek treatment for eating problems if it was necessary or advised, 22 (82%) responded positively, while 5 (19%) would not seek treatment. Participants were asked to select all that applied from a list of seven options, including "other" for not seeking medical treatment. The reasons selected for not seeking medical care were feelings of embarrassment, bringing shame to one's family, denial, and the social stigma attached to a mental illness.

The following were selected as factors which would influence the participants decision whether or not to seek treatment for eating problems or other illness: family upbringing ($n = 13$, 49%), values and opinions of family ($n = 8$, 30%), opinions of friends ($n = 6$, 23%), "other" ($n = 4$, 15%) to include personal decisions and feelings of embarrassment, and religious reasons ($n = 1$, 4%). None of these results appeared to be correlated with age since each factor was selected by participants of various ages.

Participants were asked to rank a list of individuals whom they would seek if they needed help regarding eating problems. The results, from the first to the last to be sought for assistance, were: friend/peer; family member; general physician and nutritionist (tied for third); nurse; occupational therapist; religious figure; folk healer; and "other" to

include the “Anonymous” hotline for eating disorders as described by one participant (see Table 6).

Societal Influences

Participants were asked to rank a list of possible influences for their eating attitudes, with 1 being the most influential. The option of “other” was provided for responses not covered in the list along with space for an explanation. Some participants selected items via a check mark rather than ranking one, two, and so forth. Peers and family were tied for most influential ($\underline{n} = 6$, 23% for each) and selected via check marks by an additional eight participants (peers, $\underline{n} = 6$; family, $\underline{n} = 2$). Peers was also ranked second along with television ($\underline{n} = 6$, 23% for each). Television was ranked third ($\underline{n} = 6$, 23%) and selected by three additional participants. Books/magazines was ranked fourth ($\underline{n} = 8$, 30%) and selected by four participants, followed by religion which ranked fifth ($\underline{n} = 7$, 26%). The option of “other” was selected ($\underline{n} = 3$, 12%) to include one’s appetite, weight goals, and personal preferences as additional influences. The data from twelve participants who rank-ordered rather than selected the options are presented (see Table 7).

A majority ($\underline{n} = 19$, 71%) of the women in the sample feel pressured by society to be slim while almost one-third ($\underline{n} = 8$, 30%) of them do not. The degree of pressure varied between “high” ($\underline{n} = 11$, 58%) and “moderate” ($\underline{n} = 8$, 43%). The option of “low” was not selected by any of the participants.

Participants were asked to describe ways in which they were pressured by society to be slim. Society’s emphasis on physical attractiveness, particularly thinness, is apparent

Table 6**Individuals Sought for Eating Problems (N = 27)**

Rank	Individual
1	friend/peer
2	family member
3	physician, nutritionist
4	nurse
5	occupational therapist
6	religious figure
7	folk healer
8	other (Anonymous hotline)

Table 7**Factors Influencing Eating Attitudes (n = 12)**

Rank	Factor(s)
1	peers, family
2	peers, television
3	television
4	books/magazines
5	religion
6	other (appetite, personal preferences)

in the following responses from participants: “society has been brainwashed to believe that thin is beautiful,” “people care about the way you look a lot!,” “everyone seems to have to be thin or else...,” and “no one wants to be overweight.” The media was implicated as a major influence from the popular responses of advertisements, particularly for diet foods; actresses on film and television; cover models; and fashion/clothing styles. There is the message that in order to be considered attractive, one must conform to society’s ideal of beauty, which is thinness.

Filipino Identity

Participants were asked to rate their Filipino identity from a scale ranging from very strong to very low. The majority of the women expressed having a strong Filipino identity. The results were: “very strong” ($n = 11$, 43%), “strong” ($n = 11$, 43%), “moderate” ($n = 2$, 8%), “low” ($n = 1$, 4%), and “very low” ($n = 1$, 4%).

Parental Control

Participants rated the level of parental control in their families. The majority of the respondents, 62% ($n = 16$), indicated strong or very strong parental control in their family. The results were: “very strong” ($n = 7$, 27%), “strong” ($n = 9$, 35%), “moderate” ($n = 6$, 23%), “low” ($n = 3$, 12%), and “very low” ($n = 1$, 4%).

General Filipino Beliefs

Participants described beliefs specific to the Filipino culture that influence their behaviors and attitudes, in general. There was a variety of responses with the most popular Filipino beliefs being hospitality, respect for elders, family importance, and strong family

values. There is a strong belief in being hospitable to all guests, providing food, and being friendly and social to others. Some related comments were: “guests are usually served snacks although they have not expressed any desire to be fed;” “Filipinos generally make sure all visitors and family have eaten;” “from what I learned throughout my years is to be hospitable to anyone who comes to my house;” and “food is focus of all social activities.”

Strong family values and the role of parents were deemed important as demonstrated by comments such as “the role that parents take in a child’s life is very important and highly regarded;” “listening to parents’ suggestions and respecting their decisions;” and “family comes first.” Other beliefs include the importance of education, “upholding one’s virtues and taking pride in the Filipino identity,” and upholding one’s religious beliefs. Purity and superficiality were also mentioned to describe behaviors.

Personal Experiences/Comments Related to Eating and Weight

Participants were asked to share their experiences regarding eating and weight. Comments varied among those who wanted to lose or gain weight, those who were content with their current weight, and those who have never had eating problems. Some comments were “I sometimes worry I don’t allow myself to sit down to have a healthy meal” and “I do not diet, but sometimes, I try diet food for fun. I choose what I eat. I do not deprive myself of food.” Society’s influence in promoting thinness was supported by the comment “I feel the pressure of being thin but I care more about my health than what other people think.” A participant expressed that she had a problem gaining weight; however, she preferred this rather than having to lose weight. “My biggest fear is not to be

able to eat what I want,” she further noted. Other comments included past histories of being overweight; however, through proper diet and exercise, this is no longer a problem. Another participant expressed that her eating behaviors and attitudes are influenced by the increase in health problems in society.

Upon completing the questionnaire, a participant approached the researcher and expressed some personal experiences as well as generalizations about the Filipino-American family. She stated that young children are encouraged and pressured to eat a lot; however, once they reach the mid-teens, a different message is given. This message is to lose weight if one appears to be overweight, and to maintain a smaller figure towards slimness. This participant stated that her family gave her mixed messages, encouraging her to eat as much as she wanted as a child. Upon becoming a teenager, her parents asked her “What happened? Why are you so fat?” Her family expected her to change her eating habits almost overnight. She expressed confusion regarding this and further stated that “Filipino families should make up their minds” when it comes to how they want their children to look.

Research Questions

1. What are the eating attitudes of Bay Area Filipino-American women as measured by the Eating Attitudes Test?

The results of the Eating Attitudes Test reveal that almost 20% ($n = 5$) of the participants in this sample are at risk for developing an eating disorder. The scores varied from 1 to 33 reflecting virtually no risk to high risk. Four (15%) of the participants had a

total score of 8 which was the most common score for this sample.

Dieting and food preoccupation were evident. There was a fear of being overweight (65%; $n = 17$) and thus the popularity of exercising to burn calories was reported by 57% ($n = 15$) of the women. Approximately one-third of the participants were preoccupied with the thought of having fat on their body. The majority of the participants (60%; $n = 16$) were dissatisfied with their current weight even though most of them were petite and reported average or below average weight for their height. Most preferred to lose weight while others would like to gain weight. The most common reasons selected for dieting were to enhance physical appearance and to lose weight, thus supporting the Western culture's ideal that attractiveness is associated with thinness.

Food preoccupation was revealed by 28% ($n = 7$) of the participants who indicated that they give too much time and thought to food. Abnormal eating behaviors associated with bulimia such as uncontrollable eating binges and vomiting were rare as reported by this sample.

The oral control subscale showed that 31% ($n = 8$) of the sample reported self-control around food. Some abnormal behaviors were cutting food into small pieces, others thinking they are too thin, and others pressuring them to eat.

Parental expectations of excellence and achievement orientation were addressed as possible influences for abnormal eating attitudes and behaviors.

2. What cultural factors, if any, influence Bay Area Filipino-American women's eating attitudes?

Many factors influence the eating attitudes of Filipino-American women. Peers and family were ranked as most influential; followed by television, books/magazines, religion, and one's appetite, weight goals, and personal preferences. These rankings support the importance of the family as well as the popularity of peer pressure and the media.

Societal pressures for thinness and physical attractiveness were expressed by 71% ($n = 19$) of the participants and described as either moderate or high. Media were implicated as being "messengers" for these ideals. There is a plethora of print and television advertisements for diet foods and fitness programs that particularly target females. Television and movie stars are usually thin; cover models present the glamorous life; and the fashion industry emphasizes clothing to be worn only by those with slim figures. Sociocultural risk factors also contribute to unhealthy thinking patterns regarding body image that may lead to eating disorders.

One of the participants acknowledged society's influence in promoting thinness; however, she expressed she would rather be healthy than succumb to the pressures of the "thinness ideal."

3. What beliefs affect Filipino-American women when deciding whether or not to seek treatment for an eating disorder?

Eighty-two percent ($n = 22$) of the participants indicated they would seek treatment for an eating disorder if it was necessary or advised. They reported that

treatment-seeking behaviors are primarily influenced by one's upbringing, and the values and opinions of family members. These are followed by opinions of friends, personal decisions, and religious reasons. The role the family plays during this process supports the traditional familistic orientation of the Asian culture. The patient's illness is seen as a family problem and is to be dealt with collectively rather than individually.

4. Are Filipino-American women an at-risk group for prevention activities by occupational therapists?

Almost 20% ($n = 5$) of the women in this sample are at risk for developing an eating disorder. Though this is a limited sample, this study has reflected that some Filipino-American women do have abnormal eating attitudes and behaviors that may pose a risk for the development of an eating disorder if relevant issues such as body image and self-esteem are not addressed.

A majority of the participants (65%; $n = 17$) indicated they were terrified of being overweight. They were also preoccupied with thinness and felt the societal pressures to conform to the "thinness ideal." Some of the women (60%; $n = 16$) expressed dissatisfaction with their current weight; most of them want to lose weight.

CHAPTER FIVE

PROFESSIONAL IMPLICATIONS, RECOMMENDATIONS, AND SUMMARY

The purpose of this study was to contribute to the existing studies on eating disorders as related to ethnicity. This study focused on Filipino-American women who are residents of the San Francisco Bay Area, and who may be potential participants in prevention activities with occupational therapists. It is important for health care professionals to have cultural awareness in order to provide effective therapeutic services for clients from diverse cultural backgrounds.

The results of the Eating Attitudes Test revealed that some Filipino-American women have abnormal eating attitudes and behaviors. The focus on dieting, primarily to improve one's physical appearance rather than for health reasons, suggested the adoption of Western culture's "thinness ideal." This indicates that this population could be susceptible to eating problems very much like their Caucasian counterparts.

It is relevant to discuss the philosophy of holism, which is the basis for health promotion and disease prevention. Holism is the interaction of the mind, body, spirit, and environment (White, 1986). The last component, the environment, deserves emphasis in this study because it is significant in the development of attitudes and behaviors, both healthy and unhealthy.

One of the occupational theories that considers culture and environment is the model of human occupation by Kielhofner (1980). A seminal paper for this model that

conceptualized benign and vicious cycles is relevant to this study. This theory described the individual as an open system that interacts with the environment. Cycles of interaction between the individual and the environment can result in adaptation or maladaptation, and thus defines benign and vicious cycles. This can be related to the findings of this study relevant to society's contribution to the increasing threat of the development of eating disorders.

The participants' comments citing their environment's emphasis on physical appearance has resulted in unhealthy thinking patterns among some of them. One fifth of the sample was at risk for developing an eating disorder. Also, 47% ($n = 12$) of the participants preferred to lose weight even though the majority were at average or below average weight for their height. This dissatisfaction with body image even without a significant weight problem exemplifies maladaptation and the possible start of a vicious cycle. Maladaptation occurs when an individual is unable to meet the demands of his or her environment; in this study, the demand is to conform to the thinness model for acceptance or to "fit in." Most of the participants reported dieting to primarily improve physical appearance. This may suggest the start of a vicious cycle whereby dieting can meet society's pressures for thinness, resulting in the individual feeling better about herself and receiving positive feedback from others, particularly peers. This may encourage further dieting, and if not controlled, may perpetuate a destructive cycle.

According to Striegel-Moore, Silberstein, Grunberg, and Rodin (1990), women with high achievement needs should feel compelled to pursue "achievement" in their

appearance as well, therefore increasing their risk for disordered eating. This hypothesis is not supported by the present study. Though the majority (89%) of the Filipino-American women indicated having extremely high goals, the number of participants whose scores reflected disordered eating was limited.

Society has given the message that self-worth is measured by physical appearance and image. The value placed on thinness in America has implications for all women including those from ethnic backgrounds. According to this sample, a person's upbringing, which reflects family values, is deemed significant. This influences the strength of one's Filipino identity and will most likely determine the degree of family involvement in treatment-seeking. Most of the participants reported having a strong or very strong Filipino identity, thus supporting the significance of one's family and family values during this process.

Most of the participants (62%; $n = 16$) described the parental control in their families to be either strong or very strong, followed by "moderate" (23%; $n = 6$). When relating this information to the number of individuals whose scores reflected eating psychopathology, the findings of Ahmad, Waller, and Verduyn (1994) were not supported. Their study showed that greater eating psychopathology was associated with high parental control. This sample of Filipino-American women rated their parents to be quite controlling, yet most of the scores fell under the established score for being at risk for serious problems.

Prior to seeking medical treatment for eating problems, the individuals who would

initially be sought for assistance, in the following order, were: friend/peer, family member, general physician, and nurse. These were followed by occupational therapist, religious figure, folk healer, and contacting an “anonymous” hotline for eating disorders. The latter selection, suggesting anonymity, is reflective of the negativity and shame surrounding mental illness in the Asian culture. As Sue (1994) reported, there is emphasis among Asians to bring honor to the family name and to maintain a good reputation. Mental illness may bring shame and dishonor the family, thus Asians underutilize mental health services.

Implications for the Profession

According to the American Occupational Therapy Association (1989), health promotion and wellness are the basis for prevention efforts and should be a significant part of therapeutic intervention. Though this study was limited in sample size, it showed that unhealthy attitudes and behaviors exist among Filipino-American women, thus they would benefit from prevention activities by occupational therapists.

There seems to be limited knowledge about occupational therapists and their therapeutic role for persons with disordered eating, since only a few participants selected occupational therapists as treatment resources. Occupational therapists have the knowledge and skills to provide prevention activities to reduce unhealthy thinking patterns and attitudes that contribute to eating disorders. Occupational therapy intervention would address performance areas such as activities of daily living, work, and leisure activities; components of sensorimotor, cognitive, psychosocial, and psychological performance; and performance contexts such as temporal and environmental factors (American Occupational

Therapy Association, 1994).

The traits of persons with eating disorders consist of feelings of ineffectiveness, obsessive behavior, perfectionism, preoccupation with food, introversion, achievement orientation, emotional inhibition, and social withdrawal (Beumont, 1993; Garner, 1993). These traits affect an individual's ability to successfully participate in activities, thus are addressed in occupational therapy intervention.

Psychoeducation is an efficient and effective method for delivering treatment. It is an educationally oriented group in which each session focuses on a specific topic to meet the needs of patients (Richert, 1993). Relevant topics for psychoeducation include eating disorders, body image, self-esteem, food and nutrition, social relationships, coping skills, and communication skills (White, 1992).

Activities of daily living such as the development of self-care, health maintenance, and socialization are addressed. The obvious physiological problems caused by binge eating or starvation are detrimental to a person's health. Social skills and assertiveness training would address the poor social functioning of the individual. The therapist could provide opportunities for socialization during therapeutic activities to encourage the development of interpersonal skills (Bonder, 1991).

Work and productive activities may be impaired due to perfectionistic behavior and the sense of ineffectiveness. The individual may be too focused on perfecting a product or aspect of a task, thus the process of "doing" and enjoying the activity would be neglected. According to Bonder (1991), occupational therapists address perfectionistic

behavior by limit setting during task performance, discussion of the trait, and reinforcement of behavioral change.

Opportunities for successful experiences should be provided to increase self-esteem. The introduction of new activities to develop new interests may divert attention from food and support leisure exploration (Bonder, 1991). The participation in leisure activities that are intrinsically motivating for enjoyment and relaxation would contribute to increased self-esteem.

According to Zerbe (1993), occupational therapy interventions such as art therapy, collage, and expressive groups will promote self-expression and encourage the naming and understanding of feelings. Self-management can be addressed by psychoeducation regarding coping skills, and keeping a log or journal of feelings and behaviors for self-monitoring. Milieu practices and group meetings will begin the therapeutic process and provide a structured day without the constant obsession with food. Movement groups such as Tai Chi and yoga will develop an awareness of the body. The therapeutic process should contribute to improved role performance and to one's ability to function adequately in the environment.

Prevention activities by occupational therapists include role modeling, direct education, consciousness-raising, and influencing the media (White, 1992). Occupational therapists could go in the community such as school systems and social groups to educate young men and women regarding eating disorders. The media, such as publishers and editors, should be informed of health risks caused by their emphasis on thinness and

advertisements that promote unhealthy messages (White, 1992).

White (1992) further describes the importance of direct education to adults in society who are in a position to influence young women regarding the health risks and damaging effects of eating disorders. These include ballet and gymnastics instructors, modeling agencies, and aerobics instructors. Community, athletic, vocational, and social groups with a large number of female members should be targeted.

Some of the suggestions for prevention activities by occupational therapists support Kielhofner (1995) who stated that the therapist's tool for affecting change in the human system is to change some aspect of the person's environment. Occupational therapists, via their role as educators and consultants, can implement programs of prevention activities for populations which are susceptible or at risk for developing eating disorders.

Occupational therapists should be aware that some members of ethnic groups such as Filipino-Americans have attitudes and behaviors that make them susceptible for disordered eating. As members of the growing Asian population in the United States, demographers predict that Filipino-Americans will become the largest Asian group in the near future (Sue, 1994). It is important for occupational therapists to have some knowledge of this growing group and of their culture such as their health and illness beliefs and behaviors, as they may be future recipients for prevention and therapy services.

Recommendations

Further study is recommended to include a larger randomized sample that would

challenge or support the findings of the present study, lend itself to comparisons within the group, and permit generalizability.

Future study could include Filipino-American men to determine if they are an “at risk” group as well. Comparisons could also be made between the men and women of this ethnic group to determine any patterns or similarities and dissimilarities in their attitudes and behaviors.

Other studies could include Filipino-American and other groups of Asian women, or another ethnic group altogether. Comparisons could be made between and among these groups.

Summary

This study revealed that Filipino-American women experience pressures to conform to society’s “thinness ideal” similarly to their Caucasian counterparts. As the Filipino-American population continues to grow, it is important to recognize that some women of this ethnic group have unhealthy eating attitudes and behaviors which may lead to an eating disorder. There is a fear of being overweight and preoccupation with food among this group of women.

One’s environment has a significant role in determining behaviors and attitudes, both healthy and unhealthy. Media were strongly implicated as influencing eating attitudes and behaviors, as well as peers and family members. The daily messages such as advertisements for diet foods, weight programs, consumer products, and fashion reflect some of the sociocultural risk factors that endanger the health of many individuals.

It is imperative for occupational therapists to be aware of the beliefs and behaviors of this growing ethnic group regarding health and illness. The Asian family plays a significant role in all phases of the treatment process, thus they may appear to be overinvolved; however, this is traditional in the Asian culture. To address this conflicting value, it would be helpful to include the family in all aspects of the therapeutic process. The health professional should try to establish a positive relationship with the family and patient by involving key family members in interviews, treatment planning, and other matters of importance (Nilchaikovit et al., 1993).

Occupational therapists can be instrumental in promoting the benefits of prevention activities for populations that seem to be at risk for developing eating disorders. Prevention activities would focus on psychoeducation, health promotion and wellness, direct education, and therapeutic activities in the clinical setting. This study has revealed that some Filipino-American women have unhealthy attitudes that may contribute to the development of an eating disorder and may benefit from occupational therapy services.

References

- Ahmad, S., Waller, G., & Verduyn, C. (1994). Eating attitudes among Asian schoolgirls: The role of perceived parental control. International Journal of Eating Disorders, 15, 91-97.
- American Occupational Therapy Association. (1989). Occupational therapy in the promotion of health and the prevention of disease and disability (position paper). American Journal of Occupational Therapy, 43, 806.
- American Occupational Therapy Association. (1994). Uniform terminology for occupational therapy (third edition). American Journal of Occupational Therapy, 48, 1047-1054.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: American Psychiatric Association.
- Anderson, J. (1983). Health and illness in Pilipino immigrants. Western Journal of Medicine, 139, 811-819.
- Banks, C. G. (1992). "Culture" in culture-bound syndromes: The case of anorexia nervosa. Social Science Medicine, 34, 867-884.
- Beck, N. L. (1993). Eating disorders: Anorexia nervosa and bulimia nervosa. In H. L. Hopkins & H. D. Smith (Eds.), Willard and Spackman's occupational therapy (pp. 584-588). Philadelphia: J. B. Lippincott.
- Beumont, P. (1993). Treatment of anorexia nervosa. The Lancet, 341, 1635-1640.
- Bonder, B. (1991). Psychopathology and function. NJ: Slack.

- Brumberg, J. J. (1988). Fasting girls. Cambridge, MA: Harvard University Press.
- Bryant-Waugh, R., & Lask, B. (1991). Anorexia nervosa in a group of Asian children living in Britain. British Journal of Psychiatry, 158, 229-233.
- Cooper, P. J., Charnock, D. J., & Taylor, M. J. (1987). The prevalence of bulimia nervosa: A replication study. British Journal of Psychiatry, 151, 684-686.
- Dillard, M., Andonian, L., Flores, O., Lai, L., MacRae, A., & Shakir, M. (1992). Culturally competent occupational therapy in a diversely populated mental health setting. American Journal of Occupational Therapy, 46, 721-725.
- Dolan, B. (1991). Cross-cultural aspects of anorexia nervosa and bulimia: A review. International Journal of Eating Disorders, 10, 67-78.
- Donaldson, K. (1986). Occupational therapy in an acute care setting: A generalist approach. Unpublished master's thesis, San Jose State University.
- Garner, D. M. (1993). Pathogenesis of anorexia nervosa. The Lancet, 341, 1631-1634.
- Garner, D. M., Garfinkel, P. E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. Psychological Reports, 47, 483-491.
- Garner, D. M., Olmsted, M., Bohr, Y., & Garfinkel, P. (1982). The eating attitudes test: psychometric features and clinical correlates. Psychological Medicine, 12, 871-878.
- Johnson, J. (1986). Wellness and occupational therapy. American Journal of Occupational Therapy, 40, 753-758.

Kielhofner, G. (1980). A model of human occupation; Part 3: Benign and vicious cycles. American Journal of Occupational Therapy, 34, 731-737.

Kielhofner, G. (1995). A model of human occupation: Theory and application (2nd ed.). Baltimore: Williams and Wilkins.

Levy, L. L. (1993). Occupational therapy's place in the health care system. In H. L. Hopkins & H. D. Smith (Eds.), Willard and Spackman's occupational therapy (pp. 357-368). Philadelphia: Lippincott.

McAvoy, B., & Donaldson, L. (1990). Health care for Asians. Oxford, England: Oxford University Press.

Montepio, S. N. (1986). Folk medicine in the Filipino-American experience. Amerasia, 13, 151-162.

Murray, S., Touyz, S., & Beumont, P. (1988). Knowledge about eating disorders in the community. International Journal of Eating Disorders, 9, 87-93.

Nilchaikovit, T., Hill, J., & Holland, J. (1993). The effects of culture on illness behavior and medical care. General Hospital Psychiatry, 15, 41-50.

Pate, J. E., Pumariega, A. J., Hester, C., & Garner, D. M. (1992). Cross-cultural patterns in eating disorders: A review. Journal of American Academy of Child and Adolescent Psychiatry, 31, 802-809.

Pope-Davis, D., Prieto, L., Whitaker, C., & Pope-Davis, S. (1993). Exploring multicultural competencies of occupational therapists: Implications for Education and Training. American Journal of Occupational Therapy, 47, 838-843.

Pumariega, A., Gustavson, C., Gustavson, J., Motes, P., & Ayers, S. (1994).

Eating attitudes in African-American women: The Essence eating disorders survey. Eating Disorders, 2, 5-16.

Richert, G. (1993). Program planning, development, and implementation. In H. L. Hopkins & H. D. Smith (Eds.), Willard and Spackman's occupational therapy (pp. 553-554). Philadelphia: Lippincott.

Silverstein, B., Perdue, L., Peterson, B., & Kelly, E. (1986). The role of the mass media in promoting a thin standard of bodily attractiveness for women. Sex Roles, 14, 519-532.

Smith, J., & Krejci, J. (1991). Minorities join the majority: Eating disturbances among Hispanic and Native american youth. International Journal of Eating Disorders, 10, 179-186.

Smith, M. C., Pruitt, J. A., Mann, L. M., & Thelen, M. H. (1986). Attitudes and knowledge regarding bulimia and anorexia nervosa. International Journal of Eating Disorders, 5, 545-553.

Striegel-Moore, R., Silberstein, L., Grunberg, N., & Rodin, J. (1990). Competing on all fronts: Achievement orientation and disordered eating. Sex Roles, 23, 697-702.

Sue, D. W. (1994). Asian-American mental health and help-seeking behavior: Comment on Solberg et al. (1994), Tata and Leong (1994), and Lin (1994). Journal of Counseling Psychology, 41, 292-295.

Thompson, B. W. (1994). A way outa no way: Eating problems among African-American, Latina, and White women. Gender and Society, 6, 546-561.

Touyz, S., & Beumont, P. (1985). Eating disorders. Sydney, Australia: Williams and Wilkins.

West, W. (1969). The growing importance of prevention. American Journal of Occupational Therapy, 23, 226-231.

White, J. H. (1992). Women and eating disorders, part I: Significance and sociocultural risk factors. Health Care for Women International, 13, 351-362.

White, V. K. (1986). Promoting health and wellness: A theme for the eighties. American Journal of Occupational Therapy, 40, 743-747.

Wilson, G. T. (1993). Relation of dieting and voluntary weight loss to psychological functioning and binge eating. Annals of Internal Medicine, 119, 727-730.

Worsnop, R. L. (1991). Asian Americans. Congressional Quarterly Inc, 30, 947-954.

Zerbe, K. (1993). Whose body is it anyway? Understanding and treating psychosomatic aspects of eating disorders. Bulletin of the Menninger Clinic, 57, 165-177.

APPENDIX A
QUESTIONNAIRE

Eating Attitudes Questions

Please place an X under the column which applies best to each of the statements. Mark only one response for each statement. Do not write your name anywhere on this questionnaire. Results will be anonymous and confidential. Please complete the entire questionnaire and answer each question carefully. Thank you!

	always	usually	often	sometimes	rarely	never
1. I am terrified about being overweight.	()	()	()	()	()	()
2. I avoid eating when I am hungry.	()	()	()	()	()	()
3. I find myself preoccupied with food.	()	()	()	()	()	()
4. I have gone on eating binges where I feel that I may not be able to stop.	()	()	()	()	()	()
5. I cut my food into small pieces.	()	()	()	()	()	()
6. I am aware of the calorie content of foods that I eat.	()	()	()	()	()	()
7. I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.).	()	()	()	()	()	()
8. I feel that others would prefer if I ate more.	()	()	()	()	()	()
9. I vomit after I have eaten.	()	()	()	()	()	()
10. I feel extremely guilty after eating.	()	()	()	()	()	()
11. I am preoccupied with a desire to be thinner.	()	()	()	()	()	()
12. I think about burning up calories when I exercise.	()	()	()	()	()	()
13. Other people think that I am too thin.	()	()	()	()	()	()
14. I am preoccupied with the thought of having fat on my body.	()	()	()	()	()	()
15. I take longer than others to eat my meals.	()	()	()	()	()	()
16. I avoid foods with sugar in them.	()	()	()	()	()	()
17. I eat diet foods.	()	()	()	()	()	()
18. I feel that food controls my life.	()	()	()	()	()	()
19. I display self-control around food.	()	()	()	()	()	()
20. I feel that others pressure me to eat.	()	()	()	()	()	()

	always	usually	often	sometimes	rarely	never
21. I give too much time and thought to food.	()	()	()	()	()	()
22. I feel uncomfortable after eating sweets.	()	()	()	()	()	()
23. I engage in dieting behavior.	()	()	()	()	()	()
24. I like my stomach to be empty.	()	()	()	()	()	()
25. I enjoy trying new rich foods.	()	()	()	()	()	()
26. I have the impulse to vomit after meals.	()	()	()	()	()	()
27. My parents have expected excellence of me.	()	()	()	()	()	()
28. I have extremely high goals.	()	()	()	()	()	()

29. Height: _____ ft. _____ in.

30. Current weight: _____ lbs.

31. Are you satisfied with your current weight? _____ yes _____ no

32. If "no" to question #31, how much would you like to weigh? _____ lbs.

33. If you have ever been on a diet, what were your reasons for doing so? (Check all that apply)

_____ to lose weight	_____ pressure from family
_____ to feel better	_____ pressure from friends
_____ to look better	_____ other (Please indicate): _____

34. How would your family react to your dieting behavior? (Choose one response only)

_____ support me
_____ discourage me
_____ don't care
_____ unaware that I am dieting
_____ other (Please indicate): _____

35. Have you ever received treatment for an eating disorder (anorexia nervosa or bulimia)? _____ yes _____ no

36. Would you seek treatment for eating problems if you felt the need or were advised?
 _____ yes _____ no

37. If "no" to question #36, why wouldn't you seek treatment? (Check all that apply)

- ☐ feel scared
☐ feel embarrassed
☐ bring shame to my family
☐ religious reasons
☐ denial of problem
☐ social stigma
☐ other (Please describe): _____

38. Which personal beliefs influence your decision whether or not to seek treatment (for eating problems or other illness)?

- ☐ family upbringing
☐ values and opinions of family (Please describe): _____
☐ opinions of friends
☐ religious reasons
☐ other (Please describe): _____

39. Who would you seek if you needed help regarding eating problems? (Rank all that apply, with 1 being the first you seek)

- ☐ family member
☐ friend/peer
☐ general physician
☐ nurse
☐ occupational therapist
☐ folk healer
☐ nutritionist
☐ religious figure
☐ other (Please indicate): _____

40. Which of the following influence your eating attitudes? (Rank the following with 1 being the most influential)

- ☐ television ☐ family members
☐ books/magazines ☐ religion
☐ peers ☐ other (Please specify): _____

41. Do you feel pressured by society to be slim? _____ yes _____ no

If "yes", indicate degree of pressure (Check one only)

High () Moderate () Low ()

42. If "yes" to question #41, in what way(s) do you feel pressured by society? (Please explain). _____

Demographic Information

43. Age: _____ years

44. Were you born in the United States? _____ yes _____ no

45. If “no” to #44, how many years have you lived in the United States? _____ years

46. How would you describe your Filipino identity? (Choose 1 of the following)

_____ very strong

_____ strong

_____ moderate

_____ low

_____ very low

47. Parental control in your family is: (Choose 1 of the following)

_____ very strong

_____ strong

_____ moderate

_____ low

_____ very low

48. Describe any beliefs specific to the Filipino culture that influence your behavior and attitudes, in general.

49. Additional comments regarding your experiences with eating and weight.

Thank you very much for your time. Your assistance is greatly appreciated!
 Your completion of this questionnaire is your consent to be included in the study.

Questions 1-26 (Eating Attitudes Test-26) by Garner, D. & Garfinkel, P. (1979); Garner, D., Olmsted, M., Bohr, Y., & Garfinkel, P. (1982).

Eating Attitudes Test (EAT-26)

1. Age _____ 2. Sex _____ 3. Height _____ 4. Current Weight _____
5. Highest Weight (excluding pregnancy) _____ 6. Lowest Adult Weight _____
7. Level of Education Completed: _____ Grade School _____ High School _____ College
_____ Past College

Please check a response for each of the following questions.

	always	usually	often	sometimes	rarely	never
1. Am terrified about being overweight.	()	()	()	()	()	()
2. Avoid eating when I am hungry.	()	()	()	()	()	()
3. Find myself preoccupied with food.	()	()	()	()	()	()
4. Have gone on eating binges where I feel that I may not be able to stop.	()	()	()	()	()	()
5. Cut my food into small pieces.	()	()	()	()	()	()
6. Aware of the calorie content of foods that I eat.	()	()	()	()	()	()
7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.).	()	()	()	()	()	()
8. Feel that others would prefer if I ate more.	()	()	()	()	()	()
9. Vomit after I have eaten.	()	()	()	()	()	()
10. Feel extremely guilty after eating.	()	()	()	()	()	()
11. Am preoccupied with a desire to be thinner.	()	()	()	()	()	()
12. Think about burning up calories when I exercise.	()	()	()	()	()	()
13. Other people think that I am too thin.	()	()	()	()	()	()
14. Am preoccupied with the thought of having fat on my body.	()	()	()	()	()	()
15. Take longer than others to eat my meals.	()	()	()	()	()	()
16. Avoid foods with sugar in them.	()	()	()	()	()	()
17. Eat diet foods.	()	()	()	()	()	()
18. Feel that food controls my life.	()	()	()	()	()	()
19. Display self-control around food.	()	()	()	()	()	()

	always	usually	often	sometimes	rarely	never
20. Feel that others pressure me to eat.	()	()	()	()	()	()
21. Give too much time and thought to food.	()	()	()	()	()	()
22. Feel uncomfortable after eating sweets.	()	()	()	()	()	()
23. Engage in dieting behavior.	()	()	()	()	()	()
24. Like my stomach to be empty.	()	()	()	()	()	()
25. Enjoy trying new rich foods.	()	()	()	()	()	()
26. Have the impulse to vomit after meals.	()	()	()	()	()	()

Developed by Garner, D. & Garfinkel, P. (1979); Garner, D., Olmsted, M., Bohr, Y., & Garfinkel, P. (1982).

NEUROBEHAVIORAL ASSOCIATES

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May 23, 1995

Dear Ms Lazzaro FAX 415 345-3936

Thank you for your request for information on the Eating Attitudes Test (EAT). You have permission to use the EAT in your research and clinical work and there is no charge for this permission. I would appreciate you providing me with a copy of any reports or publications in which this instrument is used since it may serve as a useful resource for other researchers and clinicians.

I have also enclosed information about the Eating Disorder Inventory (EDI-2) which is a standardized, multi-scale instrument with a much broader focus than the EAT. It is comprised of 3 subscales tapping attitudes and behaviors concerning eating, weight, and shape (Drive for Thinness, Bulimia, Body Dissatisfaction) plus subscales assessing more general psychological traits or organizing constructs clinically relevant to eating disorders (Ineffectiveness, Perfection, Interpersonal Distrust, Interoceptive Awareness, Maturity Fears, Asceticism, Impulse Regulation, and Social Insecurity).

The EDI-2 manual, test booklets, the EDI-2 symptom checklist and profile forms are available from the publisher, Psychological Assessment Resources, P.O. Box 998, Odessa FL 33556. You can call PAR at 1-800-331-8378.

If you have further questions, please do not hesitate to contact me.

Sincerely,

David M. Garner, Ph.D.

Thanks for your interest

APPENDIX B
SCRIPT

Script

I am currently a graduate student in occupational therapy and in the process of writing a thesis. I am conducting a study of eating attitudes of Filipino-American women. The study will identify any current or potential eating problems that may indicate a need for prevention activities by occupational therapists in the Filipino-American community. The results will contribute to existing research on ethnic groups and eating patterns.

I am requesting your participation in this study by completing a questionnaire. Your participation is voluntary and your individual responses will remain confidential. If you agree to participate, please complete the questionnaire and return it to me. If you have any questions, please let me know. Thank you for your assistance.

APPENDIX C
COVER LETTER

College of Applied Sciences and Arts • *Department of Occupational Therapy*
One Washington Square • San José, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

Dear Participant:

I am requesting your participation and assistance in completing my Master's thesis, "Eating Attitudes of Filipino-American Women". The results of this study will determine if Filipino-American women are an "at-risk" population for the development of abnormal eating attitudes that may precipitate an eating disorder, and thus the potential need for prevention activities by occupational therapists. Your agreement to spend approximately 15 minutes to complete the attached questionnaire will increase my knowledge and contribute to the existing research on ethnic groups and eating patterns.

You should understand that your participation is voluntary and that choosing not to participate in this study, or in any part of this study, will not affect your relations with San Jose State University or Akbayan. No service of any kind, to which you are otherwise entitled, will be lost or jeopardized if you choose not to participate in the study.

This questionnaire is anonymous (please do not provide your name on the questionnaire). No risks are anticipated by participating in this study.

The results of this study may be published. Since your responses are anonymous, no information that could identify you will be included.

If you have any questions about this study, I will be happy to talk with you. I can be reached at (415) 574-3027. If you have questions or complaints about research and subjects' rights, please contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

Your completion of the questionnaire is your consent to be included in the study.

Thank you very much.

Sincerely,

Josephine Lazaro
Occupational Therapy Student