A Brave New Ending:
Embracing Cultural, Ethnic, Racial, and Religious Diversity in Eating Disorder Treatment

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Getting Started

- This is not inclusive of all groups!
- Making the most generous assumptions of each other
“Yes, we need to own a million heartbreaking stories of discrimination and prejudice, and make millions of changes, and hold space for a million tough conversations. But, if each one of us owns one story and makes one change and has one honest conversation where we listen more than defend or offer false comfort – we can do this. There is a way to write a brave new ending to one of the most painful stories in our history. What remains to be seen is if we have the will and courage.”

-Brené Brown, PhD, LMSW
Clinicians are less likely to assess for and/or assign an eating disorder diagnosis to Black, Hispanic, Native American, and Asian patients.

Clinicians are also less likely to refer patients from these groups for further evaluation or care, no matter how severe their symptoms.

(Becker, Franko, Speck, & Herzog, 2003; Brattole, Wingate, & Joiner, 2006)
Where we’ve gone wrong:

- Neglect and lack of education from treatment community leads to underreporting of symptoms and being less likely to seek treatment.

- Minorities are more likely to have barriers to treatment than their white counterparts, which creates underrepresentation in research studies.

- Lack of diversity amongst eating disorder professionals

- Cultural bias in DSM-5 criteria
Avoidant/Restrictive Food Intake Disorder

Diagnostic Criteria

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one’s body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Anorexia Nervosa

Diagnostic Criteria

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of gender and age.

Binge-Eating Disorder

Diagnostic Criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry.
4. Eating alone because of feeling embarrassed by how much one is eating.
5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Bulimia Nervosa

Diagnostic Criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
Objectives

- Dispel **myths and misconceptions** related to the prevalence of eating disorders in various cultural, ethnic, racial, and religious groups.

- Identify **core issues, psychological characteristics, and risk factors** of eating disorders in diverse populations; as well as protective factors to aid prevention and recover.

- Ensure **effective clinical practice** with individuals in diverse populations.
## Myths & Misconceptions

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<tr>
<th>Myth</th>
<th>Reality</th>
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<tr>
<td>“Eating disorders are a white girl problem.”</td>
<td>• Young black women as likely to report binge eating/purging cycle; more likely to report binge eating, fasting, laxative, and diuretic abuse.</td>
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<td>• Hispanics have the highest incidence of bulimia nervosa</td>
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<td>• In a study of Native American 7-12th graders, 28% of girls and 21% of boys reporting purging behavior in the past year. 48% of girls and 31% of boys reported dieting</td>
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<td>“People of color do not have don’t have body image issues.”</td>
<td>• A January 1994 Essence Magazine survey of black women found that 71.5% of respondents reported being preoccupied with a desire to be thinner, being overweight, or with fat on her body.</td>
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<td>• Normal to overweight white, Hispanic, and Asian girls reported similar levels of body dissatisfaction; while Hispanic and Asian girls in the lowest 25% reported significantly more body dissatisfaction than white girls</td>
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<td>• Asians who move to America often develop a fear of gaining weight</td>
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Risk Factors & Core Issues

- **Genetics & Biology**
  - Body type differences in the midst of pressures of western body standards

- **Family & Relationships**
  - Food is the symbol of abundance and hospitality; and cleaning your plate is a sign of respect

- **Sociocultural Influences**
  - Eating customs
  - Conflicting cultural expectations

- **Life Transitions**
  - Lack of ritual and culturally competent support
  - Experiences of 1st generation Americans

- **Shame**
  - “Have to be twice as good as a white person”
  - Perfectionism related to role-model responsibility

- **Trauma**
  - Traumatic stress of racism, poverty, and transgenerational trauma
“Body hate is for white chicks.”

“Helping professionals don’t get it. They can’t be trusted.”

“We don’t do therapy. We do church.”

“I shouldn’t have this problem.”

“I’m alone.”

“My family went through slavery, famine, war... and I’m just doing this to myself.”

Drawing by Maria Fabrizio for NPR
Effective Theoretical Approaches

- Incorporation of ritual, memorial, and symbolism
- Existential
- Experiential
- Feminist
- Narrative
- Strengths-Based
- Spiritual
- Family
Multicultural Clinical Practice

1. Recognize and value differences.
2. Be curious and open to learning.
3. Be sensitive to differences in support systems and foster those relationships.
4. Accept that representation matters.
Our Ethical Responsibility

• Provide scholarships, sliding fee scales, etc.

• Educate communities that have been underserved by our specialty

• Challenge yourselves and each other

• Support awareness efforts
  • www.solacefilm.com
Resources

- Adios Barbie – www.adiosbarbie.com
- Nalgona Positivity Pride – www.nalgonapositivitypride.com
- Thick Dumpling Skin - www.thickdumplingskin.com
- *A Hunger So Wide and So Deep: A Multiracial View of Women’s Eating Problems* by Becky Thompson
- *Not All Black Girls Know How to Eat: A Story of Bulimia* by Stephanie Covington Armstrong
Questions or Assistance

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References

References