Bridging the Gap: Addressing the Intersectionality Between Eating Disorders, Trauma & Equity

Erikka Dzirasa, MD, MPH, DFAACAP Chief Medical Officer
Learning objectives for this session

+ Describe the association between ACEs and eating disorders
+ Explain how inequity and trauma affect the approach to care
+ Describe the importance of inclusivity in eating disorders treatment
Trauma-informed care is essential to delivering comprehensive eating disorder care.
ACES Defined

+ ACES have been classified as a public health emergency
+ 3 Categories:
  + emotional, physical, or sexual abuse
  + neglect
  + family experiences such as divorce, a sick family member or incarceration of a household member.
+ 23.5% reported one ACE and 15.8% reported four or more ACEs
+ Associated with poor psychiatric and physical health outcomes in adulthood, including PTSD, MDD, anxiety disorders, suicide attempts, substance use disorders, decreased life expectancy, and eating disorders
+ ACES also contribute to health disparities
ACES & Eating Disorders - Rienecke et al. Journal of Eating Disorders 2022, 10(1):72

+ ACEs are higher in individuals with EDs
  + sexual abuse
  + household divorce
  + household mental illness

+ Individuals with BED and OSFED had the highest rates of ACEs

+ No differences between men/female (not enough data for transgender/nonbinary)

+ Hispanic patients were more likely to report several ACEs categories, including parental divorce/separation, physical and sexual abuse, parental incarceration, and physical and emotional neglect

+ No conclusions could be made about other races, including Blacks due to small n (4 out of 1061 participants)
ACEs & Eating Disorders

- Bullying
- Racial trauma
- Weight discrimination
- Medical trauma
- Role of trauma in adulthood
- Financial hardship
- Environmental safety, homelessness
- Lack of representation in research
Too often, BIPOC, LGBTQ+, Fat, and other marginalized communities are overlooked when it comes to eating disorders.
Societal misconceptions and systemic barriers keep people from getting the care they deserve.

- Only 6% of people with EDs are “underweight”
- Black people are 50% less likely to receive and ED diagnosis or treatment.
- Hispanic individuals are less likely to be referred for treatment.
- Asian American college students have higher rates of restriction, purging, muscle building and cognitive restraint than white students.
- Native Americans/Alaska Natives are more likely to experience binge eating
- BIPOC and people who are not underweight are far less likely to be diagnosed or get care.
- Patients with public insurance are 60% less likely to receive treatment.
- Hispanic individuals are less likely to be referred for treatment.
- Asian American college students have higher rates of restriction, purging, muscle building and cognitive restraint than white students.
- 54% of LGBT adolescents have been diagnosed with a full-syndrome eating disorder during their lifetime.
People in larger bodies

+ Only 6% of people with EDs are “underweight”
+ Role of medical and weight stigma
+ Targeted by fatphobia and diet culture
+ Reinforcement of weight loss and dieting
+ Increased risk for onset of EDs
+ Delayed diagnosis and lack of treatment
+ Medical trauma

Sabrina Strings, Fearing the Black Body: The Racial Origins of Fat Phobia
Black/African/Afro-Caribbean community

- Black people are **less likely to be asked** about body image/ED behaviors
- Black people are **50% less likely** to receive and ED diagnosis or treatment
- Black teenagers are **50% more likely** to experience **binge/purge behaviors**
- Black teenagers engage in **muscularity-oriented eating behaviors**

Latina/o/e and Hispanic community

+ Hispanic individuals are **less likely to be referred** for treatment
+ **BED** is the most common eating disorder among Hispanic/Latine community
+ Hispanic individuals are significantly **more likely to suffer from BN**
+ **Acculturative stress** increases risk for onset of EDs

Asian American/Pacific Islander community

- Asian American college students have **higher rates of body dissatisfaction**
- Asian American college students have **higher rates of restriction, purging, muscle building and cognitive restraint** than white students
- Micro/macroaggressions and “othering” increase risk of EDs
- Up to **3x less likely to seek mental health treatment** due to stigma or “loss of face”
- “**Model Minority**” myth

Native/Indigenous community

+ Native Americans/Alaska Natives are more likely to experience binge eating
+ Native Americans are more likely to fear losing control over their eating
+ 27% of Aboriginal people in Australia meet criteria for an eating disorder
+ Discrimination, systemic racism, and acculturative stress are risk factors

Systemic barriers are keeping people from accessing lifesaving care.
When it comes to eating disorders, the barriers are even higher

**Broader healthcare system**
- Systemic racism
- Implicit/Explicit bias
- Lack of mental health parity
- Lack of insurance coverage due to “medical instability”
- Insurance emphasis on evidence based medicine
- Lack of coordination of care/team planning

**Eating disorder care**
- Limited options for culturally sensitive care + diverse clinicians
- Disparities (among LGBTQ+, BIPOC communities, boys/men, older individuals)
- Emphasis on underweight population
- Weight stigma/discrimination
- Focus on AN, neglecting other types of eating disorders

*Beckar, A et al* Int J Eat Disord. 2010 Nov 1; 43(7): 633–647
Add intrinsic barriers in the mix, and it’s no wonder why people don’t get care

- **Shame**, guilt, embarrassment
- **Stigma** including within cultural context
- **Mistrust** of the medical system
- Previous **traumatic** experiences
- Lack of recognition within **family, culture, and community**
- **Financial** burden of expensive treatment
- Clinician **bias** and negative interactions
- Lack of **cultural sensitivity** and understanding in care
We need to think differently about care to eradicate barriers and bring people the support they deserve.
Care needs to be accessible, centered to what each person needs, with equity at the foundation.

**ACCESS IS CRITICAL**
We need to break down barriers to bring people affordable care that works.

**PATIENT-CENTERED CARE = BETTER OUTCOMES**
We need to deliver the right care by integrating multiple modalities and individualized care plans.

**HEALTH EQUITY IS FOUNDATIONAL**
It is essential to build care for communities that have been overlooked to ensure all people can heal.
We approach care in a way that puts members at the center

**Trauma-informed**
- Ensuring physical and emotional safety
- Building trust and rapport
- The person has choice and a say in their care

**Holistic**
- In-house care teams working together
- Addressing underlying factors
- Treating co-morbid conditions
- Ongoing support

**Person-centered**
- Structuring care to get to know the member
- Understanding their experiences and goals
- Coordinating care to work for them

**Culturally sensitive**
- Vetting and hiring providers with diverse identities
- Benchmarking and training via Violet partnership
- DE&I workshops for full team
Integrating Trauma-informed Eating Disorder Care

- Assessment
- Psychoeducation
- Safety & Stability
- Readiness for Change
- Nutritional rehabilitation
- Behavior monitoring and response prevention
- Adaptive function
- Address Co-occurring psychiatric conditions
- Integrated psychotherapy approach
- Harm Reduction

Addressing Social Determinants of Health in Eating Disorder Care

+ **Healthcare Access & Quality**: Lack of insurance, public insurance, under-insurance

+ **Neighborhood & Environment**: Housing, geography, community, risk of safety

+ **Economic stability**: Poverty, lack of employment, childcare, need for government assistance, food insecurity

+ **Education Access and Quality**: Education attainment, health literacy

+ **Structural/Institutional Racism**: Discrimination, prejudice, harassment, macroaggressions, microaggressions, internalization of stigmatizing beliefs, minority stress theory

Holistic, inclusive care enables us to address these barriers.

I grew up facing food insecurity so I still feel that scarcity mindset present. I am a full time student surviving on limited funds.

I’m trying to get on the right track. I know I can. But I was assaulted and since things haven’t been the same.

I’m stressed with my job, I just moved, and my adult children have nothing to do with me...

I had gastric bypass surgery this year and still struggle with disordered eating.
Trauma informed, culturally inclusive care starts with us.
Delivering Trauma-Informed care

+ **Assessment:** Thorough, ongoing assessment of trauma, including racial and medical trauma
+ **Therapeutic Rapport:** Establish trust, encourage autonomy and dignity, acknowledge role of privilege and power dynamics
+ **Safety Assessment:** Assess for safety, including environmental safety
+ **Create a space** where your client feels heard, valued and understood
+ **Address underlying trauma:** Incorporate different modalities to compliment ED treatment
Delivering Individualized and Equitable Care

- **Customized**: Each plan should be designed to meet the specific needs of each member
- **Person-centered**: The member is the key architect of the plan
- **Holistic goal-setting**: The member sets healing goals that impact multiple areas of their life
- **Addressing barriers**: Compose a plan that both acknowledges and addresses social and emotional barriers
- **Care collaboration**: Including social/community supports, coaches, spiritual advisors, family, friends
Delivering Culturally Inclusive Care

+ **Research:** Ensure marginalized community voices are heard
+ **Training:** Ensure training in cultural competency, DEI training
+ **Self Evaluation:** Understand how privilege and implicit bias may impact your approach to care
+ **Accountability:** Hold organizations accountable by hiring clinicians and leaders from diverse backgrounds
+ **Culturally inclusive treatment modalities:** Consider including culturally relevant treatment practices and include community & social supports
Sociocultural factors impact how eating disorders affect different communities. Care that is trauma-informed, holistic, person-centered, and culturally sensitive is critical for supporting these communities. Person-centered care acknowledges each individual’s goals, barriers, and experiences, including SDoH. Integrating clinical care with community support is an effective way to address these needs and promote long-term healing.

Thank you!

Erikk Dzirasa, MD, MPH, Chief Medical Officer erikka@wearise.com