Addressing and Challenging Racism in Eating Disorders Treatment & Research

Ashley Acle, LMFT

Norman Kim, PhD

Co-Founder, Institute for Antiracism and Equity

Deputy Director, Ayana Therapy

Self-Reflection

- When you think about racism,
  - What image(s) come to mind?
  - What sounds do you hear?
  - What sensations do you notice in your body?
  - What curiosities arise about your own racial identity and experiences?
- When you think about addressing and challenging racism,
  - What sensations do you notice in your body?
  - What motivations and thoughts come to mind?

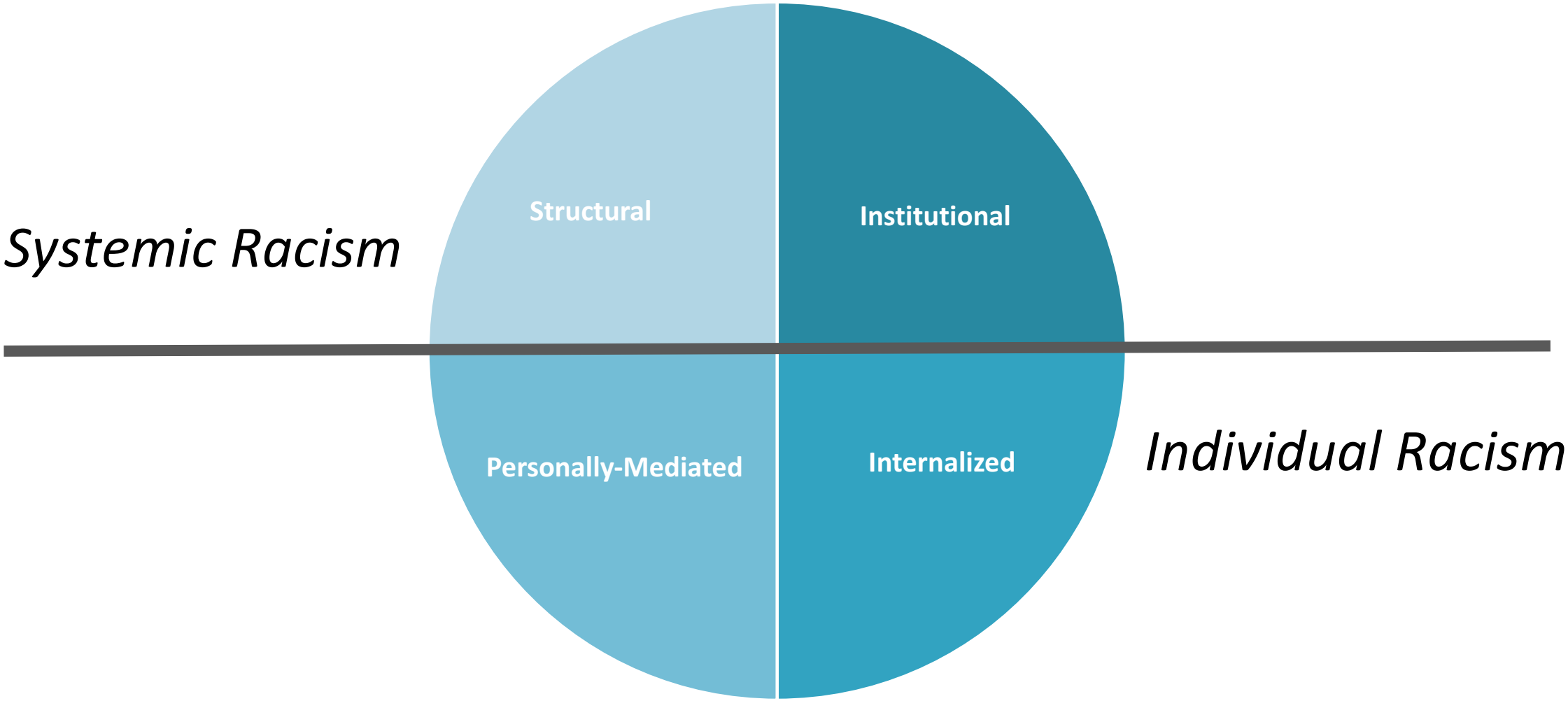
Reminders

- Conversations about racism are vulnerable and challenging.
- Acknowledge your reaction and connect with an intention or motivation for this time together.
- Be curious. This is an ongoing, collaborative journey of learning, unlearning, processing, thinking critically and empathetically attuning to experiences that are likely different from our own.
- We enter these conversations from different positions of power, privilege, knowledge and familiarity.

Terminology

- **Race:** system of structural opportunity and assigning value based on phenotypic properties (e.g. skin color, hair texture associated with race in the US), social construct
- **Systemic Racism**
  - **Institutional Racism:** differential access to goods, services and opportunities of society by “race”
    - E.g. Medical facilities, Clean environment, Information, Resources, Voice
  - **Structural Racism:** normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage and disadvantage based on “race”
- **Individual Racism**
  - **Personally Mediated Racism:** differential assumptions about the abilities, and intents of others by “race” and actions based on these assumptions
    - E.g. Police brutality, Physician disrespect, Shopkeeper Vigilence, Waiter indifference
  - **Internalized Racism:** acceptance by the stigmatized “races” of negative messages about our own abilities and intrinsic worth, accepting limitations to our full humanity
    - E.g. Self-devaluation, “White man’s ice is colder” syndrome, Resignation, helplessness, hopelessness
- **Anti-Racism:** active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes

Types & Levels of Racism



Contemporary Structural Factors

- Perpetuate histories/legacies in present day
- Policies play a significant role in
  - Segregating resources & risk (e.g. access to housing, medical care)
  - Creating inherited group disadvantage
  - Favoring differential value of life by race (e.g. histories taught)
  - Limiting self-determination (e.g. “majority rules” only when there is a fixed minority)

Jones, 2002

Institutionalized Racism in Mental Health Care

- Higher rates of psychiatric hospital admission among Black & Minority Ethnic Groups (McKenzie & Bhui, 2007)
- Greater likelihood to be admitted involuntarily if Black African, Black Caribbean or Mixed White & Black Caribbean (McKenzie & Bhui, 2007; Barnett et al., 2019)
  - Explanations cited- increased prevalence of psychosis, risk of violence, police contact, absence of or mistrust of general practitioners & ethnic disadvantage
- More likely to receive court-ordered forced medication (i.e. after refusal, history of medication non-adherence, aggression without medication) among Blacks (Thomas, et al., 2020)
- These contribute to significantly less improvement and lower likelihood to return to work in the year following hospitalization among African Americans (Eack & Newhill, 2012)

Mental Health Disparities

- Mental illness is as prevalent among African Americans, Asian Americans, Hispanic/Latinx Americans, Native Americans, and Pacific Islander Americans but they are less likely than Whites to seek mental health services
- Services were not accessible, available, or effectively delivered to these populations.
- Ethnic minority groups were found to underutilize services or prematurely terminate treatment
- Receive a lower quality of health care and have less access to care
- U.S. Surgeon General's report found that "racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity"
- The disparities exist because of service inadequacies

Cultural Diversity & Mental Health

- Cultural Views of health and illness
- Culture modifies our coping styles
- Treatment seeking varies
- Historical contexts affect how professionals are viewed
- Racism
- Bias and stereotypes
- Family
- Stigma and Discrimination

Eating Disorders in Marginalized Communities

- “I’m not as important”
- “It’s ok for me to be thrown away”
- “I deserve to be ostracized”
- Marginalization
- Eating Disorders are disorders of shame, isolation and fear

Eating Disorders in Marginalized Communities

- Risk factors for Eating Disorders
  - macro- and micro-aggressions
  - discrimination and marginalization
  - minority stress
- People in marginalized communities at particularly high risk for developing eating disorders
- When eating disorders occur in the context of already being marginalized and feeling powerless, suffering of struggling with an eating disorder is compounded

Eating Disorders in BIPOC

- Prevalence Rates
  - No significant differences in rates of Anorexia across all ethnic groups
  - Significantly higher rates of Bulimia in Latino and African American groups
  - Significantly higher rates of Binge Eating for all ethnic groups studied
- Utilization
  - Ethnic minority groups significantly less likely to utilize mental health services than non-latino Whites
  - Significant barriers to accessing healthcare services

Racism & Eating Disorder Risk

- Racism & discrimination are associated with:
  - Greater odds of Binge Eating Disorder (BED), stronger effect on African American women than men (Assari, 2018)
  - Binge eating among Native Americans/American Indians (Clark & Winterowd, 2012)
  - Body image concerns & eating disorders among Asian American women (Cheng & Kim, 2018)
- Age of help-seeking onset is often later for Blacks & Hispanics (Coffino et al., 2019)
- Clinician race-based bias can impede ED detection (Gordon et al., 2006)

Self-Reflection

- Prior to this year, how often did you:
  - Think about racism? Its impact? Who is responsible for educating/creating change?
  - Pursue learning about experiences of racism different from your own?
  - Consider the effects of racism on your professional practice and relationships?
  - Address racism in your professional work and/or advocacy?
- How are these similar and/or different this year?

Addressing Racism in Eating Disorders

- Racism: An area needing study in ED
  - No literature on systemic racism, structural or institutional racism and eating disorders as of Sept 2020
- Few resources on cultural considerations in the treatment of eating disorders
- Other areas of health have vast literature highlighting the negative impact of racism on psychological and physical health
  - Less certainty on how the application or practice of psychology can address the prevalence and impact of racism (Miller et al., 2018)

Confronting Racism in the ED Field

Confronting Systemic Racism

1. Name Racism
2. Understand the mechanisms & impacts of racism; ask “How is racism operating here?”
   - Train individuals to hold conversations
   - Enlist current antiracism trainers
3. Dismantle racism, with a focus on structures, processes of institutionalized racism, collaborative equity-oriented initiatives
   - Advocate for policy reform
   - Train, recruit the next generation of health professionals
   - Explore resources from diverse disciplines for countering racism and barriers

Adapted from Jones, 2002 & Bailey et al., 2017

Dismantling Racism in Research (Damian & Gonzalez, 2020)

1. Recruit & retain a diverse research workforce
2. Transform how we do research
   - Community-based participatory research (partnership of equals)
     - Respect the expertise of lived experience
   - Reverse the power imbalance
     - Community members take ownership
       - i.e. how research is constructed, conducted, disseminated

Self-Reflection

Recall the last in-person ED conference or workshop you attended

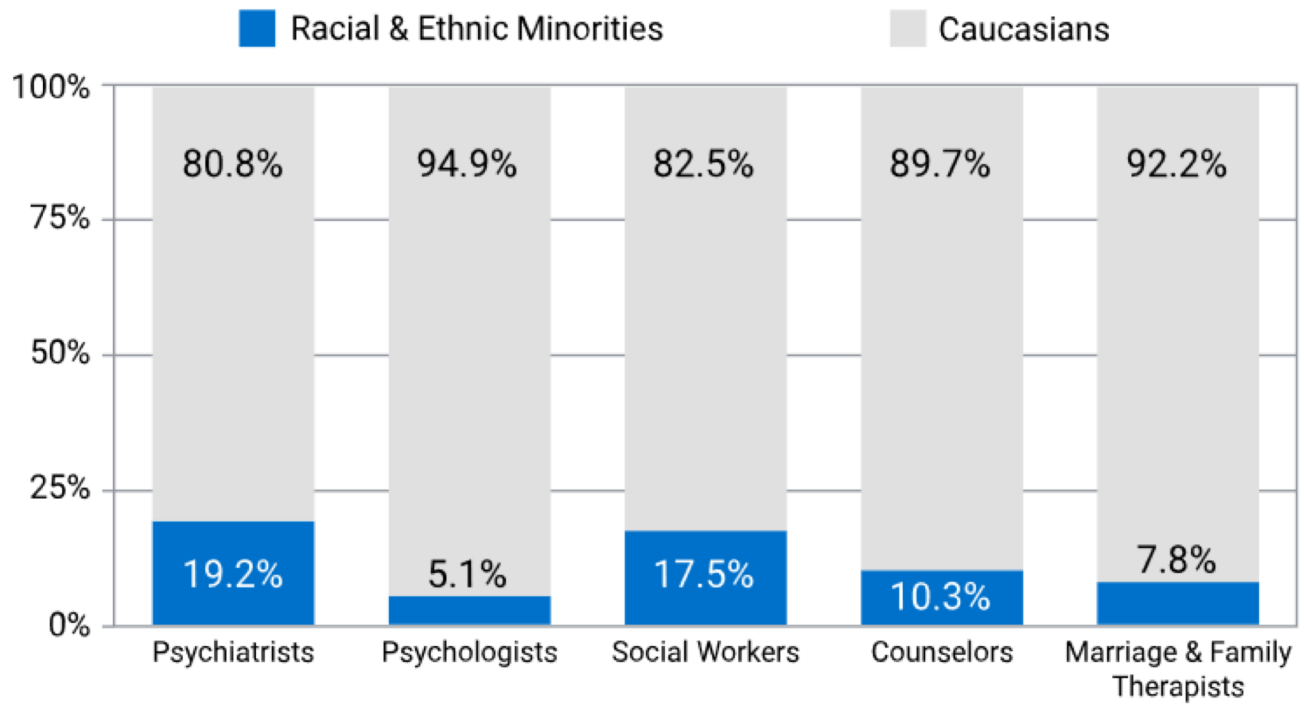
- How many of your ED colleagues were:
  - Professionals of Color?
  - Male
  - People of Size?
  - LGBTQ+?

- If you think about your close ED colleagues, are the numbers same, similar or different?
- What are the barriers in our field to increasing diverse representation?

Ethnic/Racial Matching

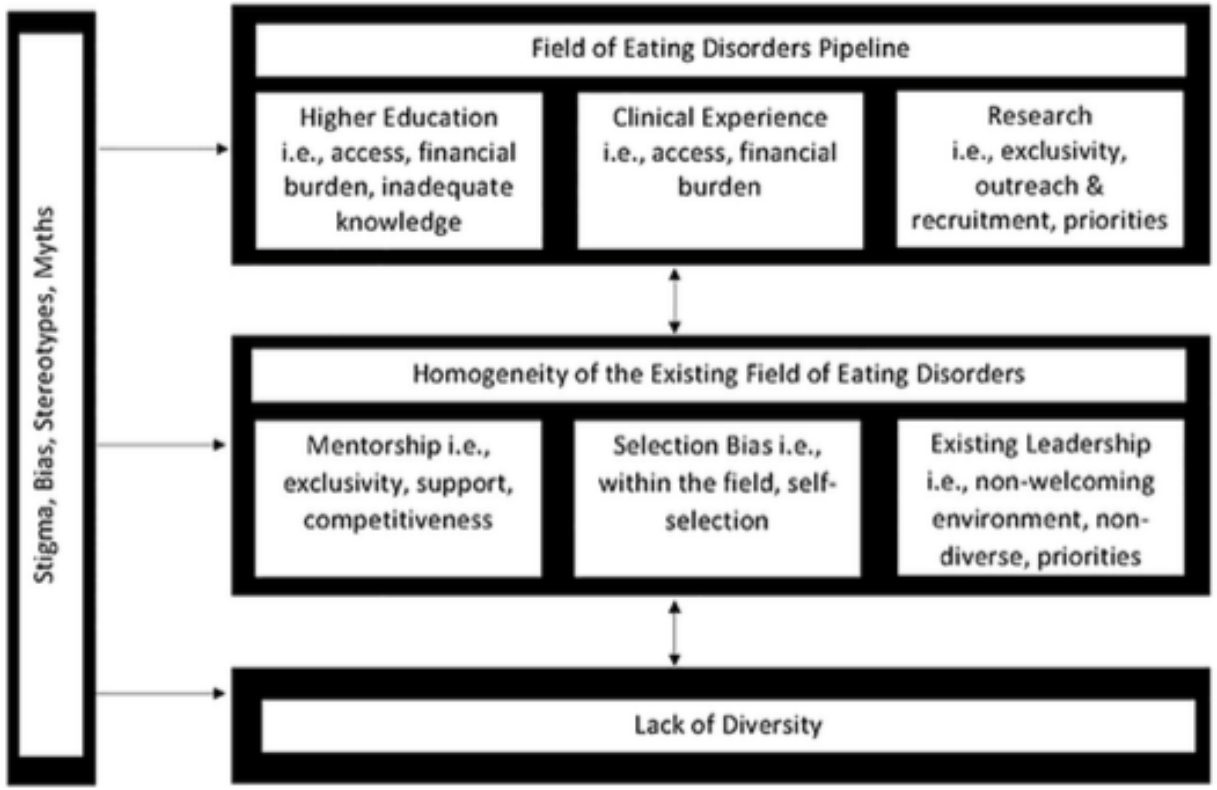
- Worldview similarities foster trust
- Interpersonal similarities influence perceptions of interactions
- But clients and therapists of same ethnicity/race might be very dissimilar
- Data about outcomes complicated
  - *"Match is neither a necessary nor a sufficient condition for positive treatment outcomes. In other words, match may be important for some, but not all, clients"* (Sue, 1998, p. 444)
  - Greater variability within groups
- Exception is among Black Americans

Percentage of Racial and Ethnic Minorities in Behavioral Health



Thinking Critically about Representation

- Workforce Diversity in ED (Mathis et al., 2020) revealed our field is:
  - 89.6% Women
  - 84.1% Heterosexual/Straight
  - 73.% White
- Barriers to diversity reported:
  - Stigma, Bias, Stereotypes, Myths
  - Field of ED Pipeline
  - Homogeneity of Existing Field
  - Lack of Diversity
- What are the experiences of BIPOC professionals in this field?



Increasing Representation

- Most impactful if relevant stakeholders are onboard & collaborating
  - Professional Organizations:
    - Diversity initiatives & fellowships, training for underrepresented minorities, mentorship
  - Academic Medical Centers/Treatment Settings:
    - Partner & engage in organizational efforts for recruitment and training
    - Diversity & Inclusion at the core of an organization's mission
    - Service (e.g. teaching healthcare providers about cultural differences)
  - Community Health Centers:
    - Partner to increase opportunities for hands-on training in cross-cultural work (e.g. residency training programs in community health settings)

Adapted from Lokko et al., 2016

What is Cultural Competency?

Cultural Competency

Levels of Analysis

- Provider and Treatment Level
- Agency/Institutional Level
- Systemic Level

Cultural Competency

"Culturally competent care has been defined as a system that acknowledges the importance and incorporation of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs" (Whaley & Davis 2007)

Cultural Competency

Conceptualizations of Cultural Competency involve:

- The Kind of Person one is
- The Skills or Interventions one uses

Cultural Competency

Cultural Competency framework

- Cultural Awareness and Beliefs
- Cultural Knowledge
- Cultural Skills

Cultural Humility

"Underlying this approach is the understanding that "traditional behavioral health practices in the US are infused with Western, European and White American male, heterosexual ideologies."

US Department of Health and Human Services, Office of Minority Health [HHS OMH] (2013)

Colorblindness?

"A colorblind approach merely relieves the therapist of his or her obligation to address racial differences and difficulties."

- - Monnica Williams, PhD

"By taking a colorblind approach, you end up rendering invisible, and not meaningful what actually is very important."

- - Gayle Brooks, PhD, The Renfrew Center

Minority Stress (Meyer, 2003)

- Experiences of prejudice, expectations of rejection, hiding, concealing, internalized homophobia require an individual to adapt but also cause significant, chronic stress, which ultimately affects physical and mental health outcomes
- Underlying the concept of minority stress are assumptions that stressors are:
  - unique (not experienced by nonstigmatized populations),
  - chronic (related to social and cultural structures)
  - socially based (social processes, institutions and structures)
- "…acculturative stress occurs when an individual tries to fit in with a culture that is different from their culture of origin, and that this can lead to maladaptive coping behaviors such as unhealthy weight regulation." (Gowen et al., 1999)
- "…members of ethnic minority groups may be vulnerable to disordered eating when they attempt to cope with stress associated with discrimination, being a member of a devalued group, and conflicts between the dominant culture and their culture of heritage." (Kempa and Thomas (2000)

Cultural Competence

- A commitment to learning about your own and other cultures
- The ability to honor and respect the beliefs, languages and behaviors of the individuals and families we serve
- The ability to avoid stereotypes
- A commitment to gaining new cultural experiences, including a willingness and ability to engage with the communities of persons we serve

US Department of Health and Human Services, Office of Minority Health [HHS OMH]. (2013)

Cultural Competence

- “Culture” is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, gender identity, sexual orientation, disability, religion, income level, education, geographical location, or profession.
- Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum.

Cultural Competence

Cultural competence underscores the recognition of patients' cultures and then develops a set of skills, knowledge, and policies to deliver effective treatments (Sue & Sue, 1999).

Challenges to Applying Cultural Competence

- We should all strive to understand a client's background, ethnicity, and belief system
- We also need to first recognize and understand one's own culture and how it might influence our ability to understand and respond to a culture different from one's own.
- May be based on age, beliefs, ethnicity, race, gender, religion, sexual orientation, or socioeconomic status.

Challenges to Applying Cultural Competence

- Risk of under-attributing cultural factors
- Risk of over-attributing cultural factors
- What does it look like to understand and take cultural factors into account in implementing the program (vs. changing the program and what we do)

Keys for Cultural Competency

- Humility
- Curiosity
- Communication
- Vulnerability
- Willingness

An Invitation

We have an opportunity to

- Connect and experience our common humanity
- Engage with others with interest, openness and compassion
- Build/Strengthen allyship and advocacy for the common good
- See and create space/invite those who need to have a seat at the decision-making table
- Identify the areas of need, barriers (e.g. inaction) and come together to create powerful change

After Hours Reflections

- How can you contribute to our field paving a new path and addressing racism in ED Treatment & Research?
- What factors in our environments (e.g. practices, treatment centers) need to change?
- How do we seek accountability and support for sustaining these changes?

Resources for Continued Learning

✅ Culturally Competent Conversations, Let's Dialogue Together

3rd Tuesday of Each Month 12-1 PM PT/3-4 ET (iaedp Members only)

Register by emailing iaedpAAEDP.POCcaseconsult@gmail.com

✅ Treating Black Women with Eating Disorders: A Clinician's Guide

Edited by Charlynn Small and Mazella Fuller

Learn more about the book on MemberAAEDP

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QUESTIONS?