



CULTURALLY COMPETENT EATING DISORDER CARE IN MINORITY RACIAL AND ETHNIC GROUPS

The ability to deliver culturally-competent care is vital to decreasing disparities in eating disorder care among the Asian, Black, American Indian/Native American and Latino communities.



There is a persistent misconception that eating disorders only affect White upper-middle class females, with many of the questionnaires being developed for and tested primarily on Caucasian (White) populations. Centering eating disorder treatment on White Americans can contribute to clinician bias or underreporting of cases in minority racial and ethnic groups. Despite ethnic and racial minorities being comparable with their White counterparts in terms of eating disorder prevalence,¹ ethnic and racial minority patients are less likely to receive a referral for eating disorder treatment² and less likely to receive mental health care.³

An individual's culture, ethnic group and upbringing has a large impact on their relationship with their body, food, exercise and the healthcare system at large, affecting their ability and the ability of those in their community to understand, identify or seek treatment for an eating disorder. While sociocultural factors are well-established risk factors for disordered eating in White American women,^{4,5} evidence for a role of sociocultural factors or culture-specific factors in disordered eating in ethnic minority women is comparatively sparse,⁶ and information for ethnic minority men remains even more elusive.

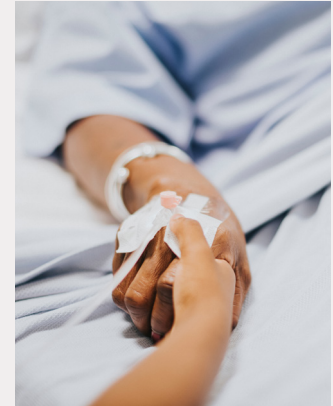
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➤ THE ASIAN AMERICAN COMMUNITY

Asian Americans are the fastest growing ethnic minority group in the United States, but remain understudied in eating disorder research. Recent research suggests that Asian American women experience comparable levels of disordered eating to White American women,^{7,8} but are often misdiagnosed or underdiagnosed. Asian Americans are three times less likely than White Americans to seek mental health services in general.⁹

One reason eating disorders go underdiagnosed is due to mental health professionals' assumptions that Asian Americans cannot suffer from an eating disorder because they are well-adjusted.^{10,11} This is an extension of the **“model minority” stereotype**,⁹ the cultural expectation placed on Asian Americans as a group to be intelligent, wealthy, obedient, hardworking and totally self-reliant.¹³



In contrast, the model minority stereotype may inadvertently prevent Asian Americans suffering from disordered eating from seeking help, due to fears of being seen as incompetent, whiny or imperfect or fear that seeking help for an eating disorder would reflect badly on their family, culture or upbringing. There can also be a cultural gap between generations in Asian American families, where older generations are not familiar with the concept of eating disorders,¹⁴ leading to pushback against receiving treatment or questioning if their eating disorder is a legitimate illness.

Cultural values that promote the idealization of thinness are also prevalent in many Asian cultures and heightens the risk for disordered eating. Persistent cultural value of thinness, perceived pressure to be thin and thin ideal internalization can predict the development of an eating disorder. This relationship has been extensively studied in White American women⁶ and emerging research suggests that it is also applicable to disordered eating risk in Asian American women,¹⁵ possibly due to shared value of thinness between Western, Asian and Asian American cultures.¹⁶

➤ THE BLACK AMERICAN COMMUNITY

Studies indicate that members of the Black community are equally or more likely to suffer from binge-eating disorder (BED) compared to White Americans. Black Americans are also less likely to suffer from anorexia nervosa^{17,18} or bulimia¹⁷ than their White counterparts. This could be explained by the fact that Black Americans tend to experience significantly lower thin idealization.¹⁹ Numerous studies show that Black women tend to idealize larger body sizes and hold body standards that are not aligned with thin idealization.^{20,21,22} Dieting and watching one's weight are also considered less congruent with the racial identity of Black Americans²³ and Black individuals are more likely to report they are smaller than they actually are.²⁴ Together, these factors may lead to the lower rates of body image disturbances and compensatory behaviors seen in the Black community.^{25,26}

The Black community is disproportionately affected by poverty, with a poverty rate of 18.8%, compared to Latinos of any race (15.7%) and over twice as high as non-Latino Whites (7.3%) and Asians (7.3%).²⁷ Black adults with continued food insufficiency were more likely to have experienced binge-eating episodes in the last 12 months, which could be a contributing factor to an increased likelihood of developing BED.²⁸

Although anorexia nervosa is less common in black Americans than in White Americans, Black Americans with anorexia nervosa tend to develop the disorder at a younger age and struggle with it for longer periods.¹⁸

Another important aspect to consider is how body shape and weight fit into larger societal beauty standards as well as beauty standards within the Black community. While Black Americans may have protective factors against eating disorders, those affected by eating disorders may have their disorder compounded by other key factors of body image in the black community, such as facial features, skin tone and hair texture.²⁹

➤ THE AMERICAN INDIAN/NATIVE AMERICAN COMMUNITY

Around 6.6 million people in the United States, or 2% of the total population, identify as Native American or Alaska Native, either alone or in combination with another ethnic identity. Around 2.5 million, or 0.8% of the population, identify as Native American or Alaska Native alone. There are 573 federally recognized tribal governments in the United States, and the largest groups in the United States by population are Navajo, Cherokee, Choctaw, Sioux, Chippewa, Apache, Blackfeet, Iroquois and Pueblo.³⁰

Due to the American Indian/Native American (AI/NA) population being small compared to non-Latino White (63.7%), Black (12.6%), Latino of any race (16.3%) and Asian (4.8%) populations,³¹ **there is significantly less data on the prevalence, sociocultural contributors or presentation of eating disorder in this ethnic group due to limited sample sizes.**

Most of the studies including AI/NA concerning eating disorders focus on high school and middle school students, which may skew findings as eating disorders in White Americans are found to be most prevalent in early adulthood, between ages 18-25.³² Recent studies suggest that the gender ratio in eating disorder prevalence in AI/NA men and women is consistent with the ratio between White men and women.⁴ Despite existing health disparities among minority ethnic groups, it is also suggested that the diagnoses of eating disorders in AI/NA women are comparable to White women.³³

➤ THE LATINO COMMUNITY

The estimated lifetime prevalence of eating disorders in the Latino population in the United States is on par with the non-Latino White population, with rates of anorexia nervosa at 0.08%, bulimia at 1.61% and binge eating at 1.92%.³⁴ While Latinos are equally as likely to suffer from an eating disorder, limited accessibility to eating disorder care and mental health care can be a barrier to the utilization of treatment. For example, Latinos with a history of eating disorders are less likely to utilize mental health services³⁵ and to be referred for further evaluation in comparison to their non-Latino White peers. Although Latinos are the largest minority population in the United States, health disparities in this population, particularly in regards to psychiatric disorders, remain evident.

Familismo (familism in English) is a central cultural value in Latino groups. Familismo refers to the cultural value that one's family is expected to provide emotional and social support, while also creating a sense of obligation to provide, take care of and consider one's family in decision-making. In Latino groups, family becomes a main source of information for behaviors and attitudes.³⁶

Latinos are typically underrepresented in outpatient settings

and underutilize mental health services. Latinos are also more likely to experience treatment disruption in the form of underutilization premature treatment termination and frequent treatment drop out compared to non-Latino Whites. The integration and understanding of cultural value familismo in treatment, through the inclusion of family or significant others in care could provide the support that patients need to engage and remain in treatment as well as improve accessibility of mental health care.^{37,38}





CULTURALLY-COMPETENT CARE IN PRACTICE

A systematic review of existing literature in social work, psychology, psychiatry and nursing identified 11 core themes⁴⁰ that may be used to inform clinical practice in the absence of more stringent research about cultural considerations in eating disorder treatment:

- **Using culturally sensitive interventions**, such as expanding clinician role, coordination with alternative medicine or community leaders and use of language to convey sensitivity
- **Addressing potential barriers to accessing treatment**, including stigma, shame, financial constraints and healthcare disparities in treatment access
- **Understanding patients within their cultural context** by exploring the patient's worldview, meaning-making and symbolism of behaviors and cultural norms.
- **Conducting a comprehensive assessment of culturally contextual factors** like gender, cultural background and values, class, ableism and educational attainment
- **Assuming a collaborative, curious therapeutic stance** and forming a strong therapeutic alliance
- **Recognizing nuances** that may impact clinical presentations
- **Exploring family/social support systems** and assessing good sources of support, family dynamics and cultural expectations
- **Providing education/psychoeducation** about eating disorders
- **Exploring ethnic identity, acculturation and acculturative stress**
- **Becoming competent at working with racial/ethnic minorities** and not perpetuating stereotypes
- **Using a culturally flexible diagnostic model**

Racial and ethnic matching is one posed solution for ensuring patients receive high-quality, culturally-competent care. However, racial and ethnic matching has its own limitations, most notably that there are fewer therapists of racial and ethnic minorities than would be needed to treat these patient populations,⁴¹ and there may be even fewer when accounting for specialty and state licensure.

Additionally, meta-analysis of racial and ethnic matching studies indicates that mental health treatment outcomes do not substantively differ when clients do or do not have a therapist of their same race or ethnicity.⁴² While patients prefer to have a provider of their own racial or ethnic group and tend to perceive these providers more positively, actual improvement in treatment is largely independent of a therapist's race or ethnicity. This underscores the importance of the ability to modify treatments to match patients' worldviews,⁴³ therapist multicultural competence,^{44,45} and professional skills development.^{46,47}

Q: WHAT IS CULTURAL COMPETENCE?

A: Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation and occupation. **Cultural competence** in healthcare is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system.³⁹

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