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Eating Disorder Literacy

Addressing a Lack of Mental Health Literacy Among Minority Cultures

INSIDE THIS ISSUE:

Special points of interest:

- More Caucasian women seek help for eating disorders but studies find an equal number of individuals among minority cultures suffer from eating disorders.
- Mental health literacy is a major factor for why many don't seek help for eating disorders.
- Primary Care Physicians need a new 'consumer oriented approach'

Those of us working in the mental health industry come into contact with a variety of people suffering from eating disorders, every day. Currently, we see far more Caucasian female patients trying to get treatment; however, studies have shown that an almost equal ratio of minorities in the United States struggle with eating disorders and are not receiving treatment. What is happening with these individuals and why aren't they getting the help they so desperately need?

When trying to answer that question we must consider a variety of factors such as: minority cultures might have different perceptions of what eating disorders are, their culture might have a different way of dealing with them, and cultural influences could attach so much stigmatism to seeking treatment that these individuals choose not to get help.

As clinicians, we need to try to understand what shapes the realities of our patients, but we should also be self-reflective and consider what biases we might be working under.

How can we improve not only understanding about eating disorders but eating disorder treatment?

This issue of *Eating Disorder Literacy* is devoted to focusing on why fewer minorities receive treatment for eating disorders, when an equal number of minorities suffer from them, and how we can bridge this gap.

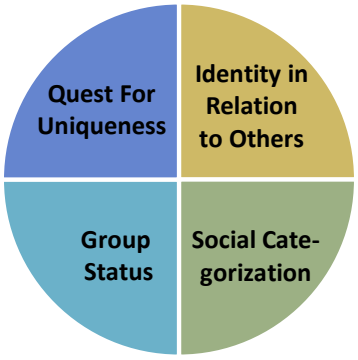
The following articles offer summaries of case studies analyzing cultural difference and influence, the importance of primary care physicians in initial diagnosis, and consideration of possible new treatment techniques to bridge cultural gaps.

How Does Culture Tie Into Eating Disorders?

Studies show females of Western societies are more likely to develop eating disorders. Yet recently, newly industrialized Eastern nations reported a rise in eating disorders. Whether this is due to better diagnosis tools or whether technology has allowed the spread of a Western media message equating thinness with beauty and success, it is important to consider and explore the possible link between eating disorders and culture.

"Theorizing Social Identity."[12]

Social Identity Theory



Social Identity theory suggests four central processes take place within a group: social categorization, development of identity in relation to others, awareness of status in relation to the dominant in-group, and the quest for psychological uniqueness.

If an individual feels as though they are being judged negatively by an in-group it could cause them to bury the aspects of their identity that keep them from fitting in.

Every individual belongs to more than one group. Some examples would be: professional, economic, gender, age, and family groups. A social identity changes depending on context and the specific group setting.

To encourage ethnic minorities to seek and stay in treatment, when designing treatment plans, clinicians must account for patients' social identity and how pressures from dominant groups can lower self-esteem and trigger eating disorder behaviors.

"Disordered Eating Related Behaviors Among Arab Schoolgirls In Israel: An Epidemiological Study."[10]

"Women use food denial as a way of 'negotiating the conflict between two worlds- whether it be a generational conflict, a work-family conflict, or a conflict between traditional and modern cultures.'"

Researchers have begun to theorize on a connection between culture and eating disorder pathology, due to the large number of eating disorder occurrences in western societies and the rising numbers of occurrences in newly industrialized eastern cultures. Traditionally, Muslim Arab populations consider 'plumpness' desirable, a sign of good health and fertility. Yet in Saudi Arabia, an industrialized nation, researchers found 20% of an Arab sample fit criteria for an eating disorder, a similar occurrence rate to Canadian female students of the same age.

Recent studies of eating disorders in both Western and Eastern cultures have found that women use food denial as a way of "negotiating the conflict between two worlds- whether it be a generational conflict, a work-family conflict, or a conflict between traditional and modern cultures" (Latzer 2007 p.268).

"Revisiting the Relationship between Eating Disturbances and Cultural Origin."[5]

There is little agreement over whether or not clinicians can predict eating disorders based on cultural background, especially since 70% of studies show no significant group differences in eating disorder occurrence.

A 1994 study by Becky Thompson demonstrated Black and Hispanic women used eating disorder behaviors to deal with racism, discrimination, poverty, and trauma.

There may be a cultural difference in what size of body is considered overweight, with black culture traditionally more accepting of larger body sizes. It is possible that the rising numbers of ethnic minority women suffering from eating disorders is due to, "an erosion of traditional values that may have been protective for some groups" (Feinson 2011 p.337).

"Eating Disturbances in White and Minority Female Dieters"[11]

Currently in the United States the majority of women who seek treatment for eating disorders are Caucasian; however, an equal number of ethnic minorities who have 'assimilated' into the dominant culture also experience eating disorder behaviors. The cultural values of dominant cultures lead to sociocultural pressures toward thinness as the desired body type. *Consumer Reports* issued a questionnaire to readers, which 21,920 people completed. All races reported the same incidence of anorexia 1% and there was no difference between ethnic groups of those who reported intentional weight loss.

Asian women, similar to Caucasian women in cultural pressures for thinness, felt the most strongly that exercise helped them to control stress and prevent over-eating.

Self-esteem seemed, universally, connected to weight with highest self-esteem at low weights, and lowest self-esteem at high weights. Black females reported the least amount of change in self-esteem connected to weight suggesting that higher weights are more socially acceptable in Black culture.

"Eating disorders lead to decreased quality of life, substantial disease burden and an increased risk of depression, substance abuse, and suicide"

"Prevalence Of Eating Disorders In The General Population."[7]

"Eating disorders lead to decreased quality of life, substantial disease burden and an increased risk of depression, substance abuse, and suicide" (Je Qian 2013 p.212).

In many countries, especially those heavily influenced by Western culture, incidents of disordered eating behaviors are on the rise especially among young females. Studies conducted in China demonstrate an increasing number of reported eating disorders over time with speculation that part of the cause might be better diagnostic screening.

Studies have shown that 3.3% of Chinese college students suffered from eating disorders, comparable to a U.S. National Comorbidity Survey which reported 2.7% of adolescent females were struggling with eating disorders.

Studies show there is a higher prevalence of eating disorders between 16-44 years of age, concluding that clinicians must focus prevention and intervention strategies on young adults.

How Important Are Primary Care Physicians in Eating Disorder Diagnosis?

Primary care physicians and school nurses are often the first individuals go to, who are struggling from eating disorders. Yet, studies show that misconceptions about the type of people who are commonly affected by eating disorders and what eating disorders are, often results in misdiagnosis.

"A Qualitative Study of Perceived Social Barriers to Care for Eating Disorders."[3]

A large percentage of those struggling from eating disorders do not seek care due to denial, limited mental health literacy, and also social factors such as cultural practices, social norms, and lack of specialty treatment facilities in the immediate area.

Sufferers may perceive the eating disorder as a character flaw, which will bring social disapproval down on the sufferer and their family. Chinese patients said it is not socially acceptable to seek help outside of the Chinese community. A Caucasian female mentioned socially, it is not polite to discuss weight.

Clinicians often fail to diagnose eating disorders due to bias and misconceptions. In the United States, studies have found physicians are less likely to ask Hispanics and Native Americans about weight related issues. Caucasian females report primary care physicians dismissing their eating disorder symptoms due to perceptions of such behaviors as 'socially normative.' Blacks have reported physicians dismissed their symptoms because ethnically they did not fit the eating disorder profile.

One patient expressed she wished her physician had asked what food meant to her, in her family (Becker 2010 p.641). The lack of empathy from clinicians often results in patients leaving treatment.

Both Caucasians and ethnic minorities identified shame, social and cultural norms as well as stereotypes about eating disorders as impediments to seeking help. It is essential to improve clinician literacy about eating disorders through training, to ensure they correctly diagnose women.

"In general, people with eating disorders tend to be ambivalent about seeking help and furthermore, it may be difficult for them to find a congenial and appropriate response to their needs"

"A Comparative Study of South Asian and Non-Asian Referrals to an Eating Disorders Service in Leicester, UK."[1]

"In general, people with eating disorders tend to be ambivalent about seeking help and furthermore, it may be difficult for them to find a congenial and appropriate response to their needs" (Abbas 2010 p.407)

A United Kingdom study reviewed case notes of patients struggling with eating disorders, reported over a 15 year span, which found that 4.6% of patients were Asian and on average were younger than Caucasian sufferers.

It is possible that it is more difficult for Asians to seek help for disordered eating based on shame, prejudice, and different ways of interpreting and dealing with mental health problems.

Once in treatment, Asians reacted to therapeutic models similarly to Caucasians patients.

Primary care physicians and those working in the mental health field need to be sensitive to the fears of those struggling with eating disorders.

"Beliefs of the Public Concerning the Helpfulness of Interventions for Bulimia Nervosa."[8]

Researchers conducted interviews in Australia with 208 women, aged 18-45 years old, using a narrative about an individual suffering from bulimia. They found the majority considered consulting a physician, counselor or dietician to be more helpful than seeing a psychiatrist. Most said they would see a physician first. Also, most perceived admission to a psych ward of a hospital to be just as harmful as trying to resolve bulimia on one's own. Only 36% perceived antidepressants to be helpful while 70% believed vitamins and minerals to be the most helpful.

While there has been some proof that St. John's Wort helps alleviate mild depression, there is no evidence that other alternative medicines help with the depression, anxiety, and OCD behaviors that often accompany eating disorders.

Therefore, mental health specialists and primary care physicians need to collaborate to ensure more individuals get the care they need.

"Poor mental health literacy may be a major factor in accounting for low or inappropriate treatment seeking among individuals affected by mental disorders"

"Eating Disorders Mental Health Literacy in Singapore:."[4]

When mental health literacy is low, the public responds with ambivalence towards consulting mental health professionals because they know very little about treatment and the treatment process.

Hong Kong, Thailand, Japan, Korea, and Singapore have reported increased cases of eating disorders among females that is as high as, if not higher than in Western Countries. In Asian cultures, family is important and often there is reluctance to discuss problems outside of the family.

In Singapore, a study of 255 women from 3 university campuses found that only 14% were able to diagnose a bulimic individual correctly. The majority responded they thought bulimia was a problem of low self-esteem and that a primary care physician, friends and family members were the individuals likely to be the most helpful when dealing with an eating disorder.

"Health Service Utilization for Eating Disorders."[9]

"Poor mental health literacy may be a major factor in accounting for low or inappropriate treatment seeking among individuals affected by mental disorders" (Mond 2007 p.405).

Common beliefs held not only by sufferers of eating disorders but also by primary care physicians are: eating disorder behaviors are normal, being honest about behavior carries social stigma, individuals should be able to handle the problem themselves, co-occurring mental health disorders like depression or anxiety should be treated first while the eating disorder is ignored, specialist eating disorder treatment has a limited benefit.

In the United States, studies have shown that female ethnic minorities are less likely to receive treatment for an eating disorder. Primary care physicians need to adopt a "consumer-oriented approach" where they are aware of the needs of minorities and "recognize individual belief systems and their potential effects on treatment seeking and adherence to treatment" (Mond 2007 p.405).

How Can Eating Disorder Treatment Become More Inclusive?

Treatment which does not engage the patient and that the patient has difficulty integrating into their life will not be successful. Clinicians must engage the patient's culture and try to understand their reality when creating an individualized treatment program.

"Race/Ethnicity, Education, and Treatment Parameters as Moderators and Predictors of Outcome in Binge Eating Disorder"[14]

In order to ensure successful treatment outcomes, clinicians must identify and resolve obstacles to treatment. Blacks and Hispanics with binge eating disorders are more likely to not seek treatment and then more likely to drop out of treatment than Caucasians. Those with only a high school education are 1.79 times as likely to relapse after treatment.

CBT and dialectical behavior therapy have proven very successful as eating disorder therapy; however, they require regular written homework and high levels of reading comprehension.

It is important to adjust some aspects of treatment for ethnic minorities because multiple studies have indicated that thoughtful, individualized treatment adaptations have successfully bridged the treatment success disparities between Caucasians and ethnic minorities.

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"The Transformation of Ms. Corazon: Creating Humanizing Spaces for Mexican Immigrant Students in Secondary ESL Classrooms."[13]

A humanizing pedagogy is a method used by a teacher in which a student's background knowledge, culture and language are valued and engaged in an effort to promote interest and learning. An instructor of ESL students found when she began to allow students to incorporate their language and culture into the curriculum and pick out topics of interest that the students became more engaged in learning.

This humanizing pedagogy is a technique which could have possible application within treatment situations. A successful therapeutic model would access an individual's culture and provide insight to therapists of the patients' reality.

"Ecocomposition and the Greening of Identity."[15]

Conscientization is a higher state of awareness which is participatory and involves understanding of how sociocultural forces shape individual lives and how it can help transform personal realities.

Understanding how place affects ethnic minorities' perceptions of personal identity can help clinicians understand a patient's reality.

Cognitivists take an interest in writing as a process that allows an individual to understand and express their internal perspective and experiences.

Each individual interprets the world and how they fit into that world, in their own way.

Clinicians can use writing in therapy to help individuals of all ethnic backgrounds come to a better understanding of the root of their eating disorder, while coming to a better understanding of who they are, and how they relate to the world around them.

"What is Literacy?"[6]

Discourse is a way of thinking and acting that identifies individuals as a member of a group. Groups hold values and viewpoints, which are illustrated through discourse, which speaks through individuals.

Learning occurs when an individual consciously processes and retains knowledge through explanation, analysis, and instruction. Acquisition is a method of learning through exposure to models or experience. In order to master new concepts, individuals need to gain understanding through acquisition as opposed to traditional learning. In therapeutic situations, ethnic minorities suffering from eating disorders may struggle to understand written or counseled treatment. Perhaps the best way for them to incorporate healthy coping mechanisms for mental health issues like depression and anxiety, is through practice and acquisition.

Understanding how place affects ethnic minorities' perceptions of personal identity can help clinicians understand a patient's reality.

"Not Writing It Out But Writing It Off: Preparing Multicultural Teachers for Urban Classrooms."[2]

Process writing is a way for people to construct and reconstruct acquired knowledge as well as confront underlying beliefs and assumptions. Often teachers who do not share the same ethnicity as prospective students feel unsure of how to connect with students and how to get students to connect with an established curriculum. However, process writing helps teachers evaluate and transcribe their most basic assumptions in a format that encourages change and revision.

In clinical application, clinicians can use journals and process writing in order to reevaluate their interactions with clients. Clinicians can also have patients who are struggling with eating disorders practice process writing to evaluate their own biases and assumptions.

Both those who seek to instruct others, as well as those who seek to learn in order to change unhealthy behaviors, should strive to question their own assumptions.

In Conclusion:

When considering the treatment gap between ethnic minorities and Caucasians, we need to consider eating disorder literacy.

Primary care physicians are generally on the front line when it comes to initial diagnosis of eating disorders. We need to ensure doctors are aware of the prevalence of eating disorders in all cultures and ensure they are sensitive to cultural differences when assessing behaviors and communicating to ethnic minority patients.

Females of all ethnicities may begin exhibiting eating disorder behaviors as adolescents and others develop behaviors under the pressures of college. School nurses are also in a key position to recognize eating disorders and recommend treatment early in the development of symptoms.

Mental health professionals need to develop and maintain relationships with nurses and primary care physicians in order to ensure eating disorder literacy and ease of referral.

As clinicians, we need to ask ourselves if the treatment we are offering is inclusive or is it exclusive and what are our goals for our patients and our facility?

Maybe it is time to take a closer look at how we are communicating to all of our patients.

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