Case Report

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Journal of Obesity & Eating Disorders
ISSN 2471-8203

2023
Vol.9 No.1:136

Weight and Race Bias as Risk Factors to the Under-Assessment and Under-Treatment of Eating Disorders: A Case Example

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Received date: April 03, 2023, Manuscript No. IPJOED-23-16220; **Editor assigned date:** April 06, 2023, PreQC No. IPJOED-23-16220 (PQ); **Reviewed date:** April 20, 2023, QC No. IPJOED-23-16220; **Revised date:** April 26, 2023, Manuscript No. IPJOED-23-16220 (R); **Published date:** May 04, 2023, DOI: 10.36648/2471-8203.9.1.136

Citation: Woodland SL (2023) Weight and Race Bias as Risk Factors to the Under-Assessment and Under-Treatment of Eating Disorders: A Case Example. J Obes Eat Disord Vol.9 No.1: 136.

Abstract

In the United States alone, 30 million people are suffering from some form of an eating disorder, globally the number increases to 70 million people. Eating disorders are the deadliest mental health disorder, killing over 10,000 people annually. Even with the high prevalence of eating disorders in this country, only 6% of people who struggle with eating disorders are diagnosed by a medical professional leaving many to remain untreated. There are many left untreated due to weight and racial bias. Mental health treatment and interventions are lifesaving, but only if we are recognizing the seriousness and totality of that individual's struggles. We need to break racial stereotypes in research because research is what are informing or misinforming the very people tasked to support and treat individuals with serious and sometimes life-threatening mental health issues.

Keywords: Eating disorders; Weight and race bias; Atypical anorexia; Affect dysregulation

Introduction

Eating disorder pathology

In the United States alone, 30 million people are suffering from some form of an eating disorder, globally the number increases to 70 million people (National Institute of Mental Health, 2022) [1]. Even with the high prevalence of eating disorders in this country, only 6% of people who struggle with eating disorders are diagnosed by a medical professional (NIMH, 2022) leaving many to remain untreated. Unfortunately, we can assume that claim of 5.5% struggling with BED, 2% struggling with bulimia and 1.2% with anorexia (NIMH, 2022) is much higher. Further, ED don't just impact adolescent girls or young women, the prevalence of anorexia, bulimia and BED is highest among 20-39 years-old (NIMH, 2022). In addition, 13% of women over the age of 50, worldwide, will experience some form of eating problems that will require some form of intervention (NIMH, 2022) [1].

This is a concerning thought because out of all the mental health illnesses, ED are the deadliest with 10,200 annual deaths, or to put it into perspective, 52 deaths every minute (NIMH, 2022). This tops the percentages of deaths from opiate overdoses (NIMH, 2022) [1]. Further, if we believe that the rates of eating disorder incidence are much higher, there are a lot of deaths unaccounted for. It is important to note that this statistic presented does not represent other feeding and eating disorders and unspecified eating disorders represented in the DSM-V-TR (2022).

Body dissatisfaction is the most notable risk factor for the development of an eating disorder [2]. The National Eating Disorders Association (NEDA) defines body image as encompassing how one feels and experiences one's body (2022) [3]. Individuals with eating disorders are more likely to have internalized the society's body ideal leading to higher rates of body dissatisfaction, body dysmorphia and poor body image (NEDA, 2022) [3]. Weight stigma or weight bias supports the idea that thinner is better which ultimately is one of the main societal factors that leads to increased body dissatisfaction (NEDA, 2022). As we will discuss, weight bias leads to seeing one as "bad" or "undeserving" leading to a greater sense of isolation and loneliness and a smaller support network with fewer friendships, which are significant risk factors in the development of an eating disorder (NEDA, 2022) [3]. The anti-obesity messaging leads to body shaming and bullying (NEDA, 2022) we see it all the time in the media and on social media. It is not uncommon that an article on body positivity is accompanied by an advertisement for a weight loss pill, program or diet **(Table 1)**.

Table 1: Diagnosis by age.

Age	BED	BN	AN
10-19 Years	1.6%	0.9%	0.3%
20-39 Years	3.5%	1.5%	0.8%
40-59 Years	2.3%	0.9%	0.5%
60+ Years	1.5%	0.5%	0.3%

Weight bias

Many individuals who are over-weight or obese, are often confronted with weight bias [4]. Weight bias encompasses negative stereotypes and attitudes towards people of a larger size that lead to discrimination [5]. Weight bias is not immune in medical or mental health settings [6], research suggests that providers may see patients as lazy or gluttonous leading them to disregard eating disorder symptomology or encouraging a treatment goal of weight loss [7]. Even trained eating disorder specialists and professionals trained in obesity can have both implicit and explicit biases towards individuals that are based on attitudes that are anti-fat or pro-thin [8]. Further, if we support a goal of weight loss, as a treatment goal, a provider might introduce iatrogenic, which can have severe or even deadly consequences [9]. If a primary treatment goal is weight loss, we need to assess further so we can gather a more accurate clinical picture of treatment needs from a more well-informed and compassionate place.

Weight bias has negative consequences on one's overall health including poor self-esteem, stress, body dissatisfaction, depression, binge-eating and an increased risk of developing an eating disorder [10]. Weight bias has also been shown to decrease the motivation for exercise, decrease quality of life and overall life expectancy [11]. Given this reality, we could argue that these consequences are much more impactful and harmful than just being overweight. Further, research has supported this Notion that body weight is caused by lifestyle factors, such as overeating and lack of exercise [12]. The idea that weight is controllable, otherwise termed as 'obesity discourse' simply by calorie intake and expenditure [13], oversimplifies the complexities of eating and weight struggles.

The belief remains in the general population and health care providers, that weight is caused by gluttony, lack of will power, or a sedentary lifestyle which supports the Notion that one's weight is a personal choice and is their personal responsibility, despite research that supports more than 100 factors and 300 connections between these factors [4]. The stronger the belief in weight control, the stronger the weight bias [8].

These unconscious biases must be acknowledged in both the medical and mental health fields if we are to support the very people we are tasked to help. Negative assumptions around people with larger bodies can impact the quality of care provided to individuals [4]. For instance, research has shown that patients with larger bodies receive communication that is less person-centered, given less time in appointments and are offered fewer treatment interventions [14]. Further, research demonstrates that mental health professionals view individuals that are larger as having poorer outcomes to treatment which leads to an avoidance of treating larger individuals or an inadequate development of treatment planning [15]. Providers may believe that their assumptions about the individual's motivation for change or likelihood of achievement of goals are based on clinical assumptions when ultimately cultural and social factors are strong influencers of these assumptions [4].

It has been argued that a dominant message in our society that supports weight bias is the idea that obesity is a moral failing [16]. In this framing, weight bias perpetuates the idea that obesity needs to be eradicated and further, that individuals bring it on themselves with poor food and exercise choices, while thinner individuals make better choices [16]. This idea is supported by governmental initiatives that provide free or low-cost gym memberships or food incentive programs aimed at providing broader access to fruits and vegetables, especially in poorer communities [17]. Further, these assumptions may initiate well-intentioned providers to encourage weight loss as a treatment goal [4]. As research has shown, engaging in dieting behavior only increases body dissatisfaction and the development of eating disorders [18].

With this dominating view of obesity, unfortunately, leads to view body sizes as either good or bad, leading to the assumption that individuals with larger sized bodies are bad people who deserve bad outcomes. For instance, Vartanian, et al. found that people with larger bodies elicit negative feelings, such as disgust and a strong desire for increased social distance among thinner individuals. This also supports the idea that thinner bodies are healthier which leads to a very inaccurate broader picture of body size and disregards the emotional component of weight and one's relationship with food and body-esteem [19].

Race and weight bias

Race biases can also lead to an under-assessment and diagnosis of an eating disorder [18]. Some suggest that part of the problem is the very act of "othering" or labeling either for body shape or race [20], which creates a distinction between "us" and "them" and to view body sizes as either good or bad, perpetuating the idea that individuals in larger sized bodies are bad people who deserve bad outcomes [4]. This also supports the idea that thinner bodies are healthier, or in the case of an assumption of an eating disorder, sicker, which neglects the emotional distress of one's weight, relationship with food and body-esteem [4].

The NIMH (2022) argues that communities of color are less likely to experience symptomology of an eating disorder and less likely to have an eating disorder. It is important to note, that the NIMH, follows that up with the statistic that Black individuals are 50% less likely to be diagnosed with an eating disorder or receive any type of treatment intervention at all (NIMH, 2022). Further, they argue that Blacks have a lesser chance of an anorexia diagnosis than White individuals even though they struggle with the identical symptoms for a longer duration (NIMH, 2022) **(Table 2)**.

There has been extensive research on pathological eating patterns in communities of color, but only as it pertains to food insecurity [21-24]. It has been argued food insecurity increases the risk for disordered eating patterns, particularly binge-eating behavior [22]. It is suggested that fluctuations in access to food can lead to disordered eating patterns of restriction when food is not available and binge eating when there is food available (*e.g.,* at the beginning of the month when food stamps are replenished or at the end of the month when food in the home is scarce) [24]. However, Woodland and Luf in, found that Blacks

and mixed-race groups report higher rates of restricting than the White sample and insignificant rates of binge/restricting eating pattern **(Table 3)**. Further, the results showed that Blacks had a higher incidence of a diagnosis of EDNOS and AAN **(Table 4)**. This suggests the need to explore racial bias in research of eating disorders, especially if we are assuming that eating pathology only occurs in poor communities of color is related only to poverty and that the pathological eating patterns are more specific to binge-eating [25].

Table 2: Diagnosis by Race from the National Institute of Mental Health (NIMH).

Race	BED	BN	AN
White	1.6%-3.5%	0.5%-1.0%	0.3%-0.4%
Latino	1.0%-3.2%	0.3%-0.9%	0.2%-1.0%
Black	2.0%-5.0%	0.5%-1.5%	0.2%-0.5%
Asian Americans	0.9%-2.7%	0.3%-0.7%	0.2%-0.9%

Table 3: Frequencies of disordered eating.

Frequencies of restricting			
Black	**Hispanic**	**White**	**Mixed-Race**
1-2x daily/ weekly	1-2x daily/ weekly	1-2x daily/ weekly	1-2x daily/ weekly
30%	14.7%	11.6%	32%
Frequencies of binging food			
Black	**Hispanic**	**White**	**Mixed-Race**
1-2x daily/ weekly	1-2x daily/ weekly	1-2x daily/ weekly	1-2x daily/ weekly
13.60%	16.4%	11.6%	20.6%
Frequencies of restricting and binging food			
Black	**Hispanic**	**White**	**Mixed-Race**
1-2x monthly	1-2x monthly	1-2x monthly	1-2x monthly
1.9%	0%	2.3%	4.1%

Table 4: Diagnosis at a community based mental health clinic.

	BED	EDNOS	AAN	AN
Black	0%	2.9%	2.9%	0%
White	4.7%	0%	0%	2.3%
Mixed-Race	1.0%	2.1%	0%	0%
Hispanic	0%	0%	0%	0%

Atypical anorexia

The DSM-V lists the first diagnostic criteria of eating disorder of restricting type as restriction of energy intake relative to requirements, without the requirement of low body weight (America Psychiatric Association, 2013) [26]. The American Psychiatric Association added the diagnoses of atypical anorexia to the fifth edition of the DSM (2013). An individual suffering from atypical anorexia meets all of the criteria of anorexia, with the exception of low body weight (APA, 2013) [26].

Some might suggest that atypical anorexia is less serious and less dangerous than anorexia [9] however individuals with atypical anorexia, similar to those with anorexia, have an intense fear of gaining weight and engage in very dangerous behaviors to control weight, such as severe food restriction, fasting, compensatory behaviors and excessive exercise [27]. Because current weights in individuals with AAN tend to be either of normal weight or overweight, many healthcare professionals neglect to assess thoroughly for an eating disorder, because of a false assumption that if one does not look emaciated, there is no eating disorder presented [27]. Unfortunately, many are left undiagnosed and untreated, leaving many not to receive any intervention until late into their illness (NEDA, 2022) [3]. However, medical complications can be just as severe in individuals with AAN compared to individuals with AN, and it has been argued that individuals with AAN have more severe pathological eating patterns [27].

Research has indicated that there are some differences in the demographic differences with those with ANN, with a higher proportion of those diagnosed as male or nonwhite [27]. Many argue that ANN is not a different condition than A but rather on the spectrum of the same condition [9].

Affect regulation

All forms of childhood trauma are positively correlated to dysregulated affective states and the development of an eating disorder [28,29]. Neglected and abused children have very little experience being soothed by their caregiver or parent earlier in life putting them at a distinct disadvantage with the inability to regulate intense emotional experiences and impulsivity [30]. It has been argued that pathological eating patterns such as binging, binging-purging and starvation are maladaptive ways in which to regulate overwhelming affective states [30]. With a majority of clients coming into mental health care with severe histories of trauma [17], it is concerning that mental healthcare providers are not only not assessing for eating disorders, but eating pathology and body image is not being explored, leaving many to suffer in silence.

Case Example

Kimberly is a 59-year-old Black woman. She struggles with atypical anorexia. Kimberly grew up an in a violent home. When she was a young child, she reports a good relationship with her mother. Her mother would take her to the park, take her to

extracurricular activities and spend time with her in the home. Unfortunately, during this time, her father was still in the home and was physically abusive to her mother. Kimberly stated that it was very conflicting to watch as her father who adored her and was very loving towards her yet at the same time violent and emotionally abusive to her mother.

Her parents divorced when she was around 9 or 10. Kimberly reported that her mother turned to religion for solace. She became increasingly rigid in her religious beliefs and soon that was all she spoke of in the home. Coincidently, shortly after her father left, her mother, who had never been physically abusive, turned her rage onto her. Kimberly reports feeling her mother resented her and the love she received from the father. Kimberly reports many times her mother would make her strip naked and beat her.

When she was around 11, she turned to starvation to help her self-soothe. She lost a great deal of weight and reported that she was "bony". No one seemed to notice that she was struggling with anorexia. Kimberly reports feeling the more she lost weight the greater the hope she would become invisible so to not be the target of the physical abuse. Unfortunately, that is ultimately what happened with everyone in her life as she was severely underweight and no one seemed to take notice.

As Kimberly entered adulthood, the physical abuse stopped but her mother continued with the emotional abuse. Kimberly also reports that her mother and brother moved in with her and expected her to provide for them. She stated that one day, it became too much and she walked out, jumped on a bus and came to NYC [31]. Kimberly had very few resources with her and ultimately became homeless.

Kimberly reports that for the first year in NYC, she was street homeless and lived under a bridge. She reports that at that time she became obese. She remembers a group of men looking out for her well-being and safety. They would bring her food every day and made sure she ate. It is important to note that this was the first time in many years that she felt that others were concerned for her well-being and though many people struggling with street homelessness report feeling dehumanized and invisible, Kimberly felt seen and cared for. Unfortunately, the internal conflict of being seen and being invisible would continue to play out in her pathological eating patterns, with her restricting as being the representative of the abuse and her over-eating as being representative of love, which ultimately always turned to shame and guilt [32].

Kimberly finally found her way to a shelter and then eventually, supportive housing. No one in her family new where she had gone or if she was even alive. After, over 10 years Kimberly finally contacted her family. That was when her eating pathology started up again. Kimberly felt mortified that her family, after so many years, was witnessing her as obese. She went to a nutritionist, who did not assess her for either trauma or past eating pathology. The encouragement from her doctor to prioritize weight loss as a treatment goal, ultimately introduced iatrogenic. Kimberly lost over one hundred pounds. Her doctor was pleased, her friends and family took notice and Kimberly reported feeling good [33].

What Kimberly did not disclose to anyone is how she lost the weight. Kimberly was restricting her calorie intake to less than 700 calories and even reported some days restricting so severely that her only intake was water. Kimberly finally sought out therapy for depression and anxiety. She was diagnosed with major depressive disorder. She was in therapy for many years and there was never a discussion around food or body image [34].

I started working with her 5 years ago. She was transferred to me at a community based mental health clinic after her former therapist left the agency. By the time she had come into my care, she had been with 4 therapists in a 5-year span, unfortunately pretty typical of a community based mental healthcare setting. At this time, Kimberly was 54 years old and had never had a diagnosis of an eating disorder, or even a discussion around food or eating behavior, even though she was very forthcoming about losing over a hundred pounds. Kimberly was considered slightly overweight at this time. Kimberly spoke often about losing the weight and her dissatisfaction with her current size. What was very evident was the torment that she experienced around her body [35].

We explored her pathological eating patterns in therapy and it turns out that she was starving herself for 3-4 days at a time, consuming nothing but coffee and water. She would finally break down and eat, only after the hunger pains became too much. She reported then "binging". The DSM-V (2013) defines binging behavior as both eating a large portion of food in a discrete period and feeling a loss of control over how much one is eating. When I explored what her idea of binging was, she reported eating comfort foods such as macaroni and cheese or fried chicken or a bowl of ice cream. However, it was never of binging proportions, which signifies why it important to explore how a client defines pathological eating [36].

Kimberly's eating stabilized when she became involved with her boyfriend. Although she still preoccupied with her body and weight, she ate normal meals. Her boyfriend new about her eating behaviors and patterns and would check on her to make sure she was eating. Unfortunately, he died of cancer during the height of the pandemic. After his death, her ED came back full force and her pattern of restricting for days and "binging" returned. Kimberly fell into a state of extreme distress. She covered every mirror in her house and became afraid to try on any of her cloths in fear of feeling her stomach against her pants. She was weighing herself 5 times a day [37].

The year anniversary of her boyfriend's passing was very difficult. She tried to numb her feelings with severe restriction. She struggled with her preoccupation of her weight and food. She would cook meals for herself, which helped connect spiritually with her with her boyfriend, who was a good cook, but ultimately, she would throw out several fully cooked meals. This is yet another example of how food and the feelings of love felt conflictual to Kimberly causing her to reject it.

Kimberly had several panic attacks when she realized that her mother did not bother leaving a voice message on the year anniversary of his death. She shared that she was able to pull herself out of the panic attacks by loudly vocalizing to herself

that her mother is not welcome in her life. We had spoken about using this tool when her thoughts got fixated on her mother or food. She began to speak about her shame around her body. We spoke about her grief around the loss of her boyfriend, as he always made her feel better about how she looked and felt. I encourage her to internalize his voice rather than her critical mother's voice.

She shared with me that her pattern of starvation brought on intense stomach pains. She had told the doctor how extreme her restricting was but neglected to share her diagnosis of atypical anorexia. Even though she shared the extent of her starvation, the doctor only responded that she should eat regularly and the stomach pains should go away.

I have worked extensively on helping Kimberly understand that she has an eating disorder. When she last went to the doctor for her annual checkup, I coached her into sharing her diagnosis and I told her it was in her control to either refuse being weighed or do a blind weigh-in. She did neither. She stated that the nurse felt so compassionate that she convinced her to step on the scale. This through Kimberly into a tailspin. Three weeks after her doctor's appointment, Kimberly reported to me that she had lost 19 pounds and she claimed that she was eating healthy. Her idea of "healthy", however, was eating a packet of oatmeal in the morning and a banana for lunch. She had stopped all food intakes at 1 pm, leaving the remaining 10 waking hours in total starvation.

She worried that she was talking too much about "how fat" she was to her family. She has a very close relationship with her father and a cousin. I encouraged her to replace "I am fat" with "I am carrying a lot of emotional pain". Her family knows very little about the extent of her childhood trauma. Her family understands her preoccupation with weight as her need to diet. Her cousin has given her diet tips and encouraged her to do weight watchers. I have encouraged her to disclose her eating disorder to them, especially her cousin who is her closest confident.

Kimberly struggles with severe restriction when a visit with her family approaches. We have spoken about how her relationship with food is a re-creation of her relationship with her mother. When she restricts, she withhold love from herself as did her mother when she was neglectful. When she binges, she is re-creating the time her mother paid attention to her when she was physically abusing her.

Results and Discussion

We discussed her relationship with her father. She is very protective of him and he is unaware of her current eating disorder. We discussed her starting to see food as not a representative of either love or abuse. She continues to struggle with boundaries with her mother which feeds into her negative self-image. We spoke about her need to get approval and praise and her ongoing disappointment with her mother's criticism and inability to support her. Her mother was highly critical of her food intake and critical of her overall.

Kimberly feels angry with herself when she calls her mother. We speak about her natural yearning to get the "good" mother on the phone, which does happen occasionally. Since Kimberly has had experience with both the "good" mother and the "bad" mother, she has internalized both. We talk about her mother's unhealed issues and I encourage her to prepare for the unpredictable when she does call her mother. Kimberly can recognize that there are a lot of people in her life that care for her and make her feel loved and good.

We have spoken about being ok with when she feels that she has "messed up" with her food intake, mainly over-eating. She does recognize when she does eat junk food her stomach is upset the next day. We spoke about the similarity of this pain when she overeats and when she starves herself. We discussed the parallel to the pain she felt when she was being beaten as a child to the pain, she inflicts on herself now with her ED. We spoke about recognizing the pattern and similarities of the abuse between her mother and the self-abuse [38].

Kimberly feels exhausted by this whole pattern of self-loathing and eating pathology. She recognizes that as she approaches her 60th birthday, she is fatigued living this way and is concerned with the long-term impact it will have on her body. She now realizes that her torment with her relationship with her mother has kept her in an emotional holding pattern. We have spoken about reframing her anorexia as not her struggle with food, but rather her struggle with her mother. Simply stated, her anorexia is her unconscious struggle with her abusive relationship with her mother.

Importance of assessment

Kimberly is just one example of how severe eating pathology can be, even when someone isn't underweight. Kimberly's whole life is consumed with her eating disorder; both her pathological eating patterns and her negative feelings around herself and body esteem. This type of eating pathology can and will have severe consequences on one's emotional and physical health. As we see with the case of Kimberly, her trauma is pervasive and her eating pathology is a trauma reaction. If we are working with clients with severe trauma histories, we must assess them for eating disorders. As discussed above, like any addiction, individuals with severe trauma histories are at a much higher risk for dysregulated emotional states. As for the case of Kimberly, she uses starvation and "binging" to try and regulate her affective states, especially after she speaks to her mother.

Further, we must address and break the biases around weight and race as it relates to eating disorders. For example, the doctor that advised Kimberly to "just eat", minimizes the deeper issues around abuse, self-loathing or the overwhelming feelings of emotional pain. Ultimately, it repeats the pattern of emotional neglect and reinforces the idea that she is not worth being cared for, even by the very people who are tasked to do so.

Conclusion

Most importantly, we need to address the issues around eating disorders from a trauma-informed lens with an

understanding that eating disorders do not just impact young white women and people in larger bodies. Mental health treatment and interventions are lifesaving, but only if we are recognizing the seriousness and totality of that client's struggles. We need to break racial stereotypes in research because research is what is informing, or misinforming the very people tasked to support and treat individuals with serious and sometimes life-threatening mental health issues.

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