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Dying To Eat: The Under-Assessment of Eating Disorders in Marginalized Communities

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Abstract

Obesity has become a major health crisis in the United States and often leads to other significant health problems, such as heart disease and diabetes. This epidemic has hit marginalized communities hardest, with unemployment, financial stress and poverty as strong indicators for weight gain and weight problems. This article explored factors that lead to obesity, mainly food insecurity and early childhood trauma. We conclude that to address this epidemic, obesity needs to be viewed from a social justice perspective as well as a clinical perspective. Individuals of color are not being assessed for eating disorders, leaving pathological eating patterns and motivations unaddressed and ultimately untreated.

Keywords: Eating disorder; Binge eating disorders; Childhood trauma; Affect regulation; Food insecurity; SNAP; Obesity; Diabetes; Emotional neglect; Minorities

Abbreviations: ED: Eating Disorders; BN: Bulimia Nervosa; AN: Anorexia Nervosa; BED: Binge Eating Disorder; EDNOS: Eating Disorder Not Otherwise Specified; SNAP: Supplemental Nutrition Assistance Program

Background

The prevalence of obesity has become a major health crisis in the United States in recent decades. According to the Centers for Disease Control and Prevention, nearly two-thirds of adults are considered overweight and more than one-third are considered obese (2016). This is a significant public health concern, with obesity being associated with several comorbidities, such as cardiovascular disease and diabetes, as well as medical costs rising above $147 billion annually [1]. It is crucial that we understand the causes of obesity to better identify helpful and lifesaving interventions.

This article will focus on how racial and socioeconomic disparities impact eating behavior. Further, we will be exploring obesity through the clinical perspective of eating disorders, more specifically binge eating disorder. Finally, it will be argued that without seeing this epidemic in marginalized communities through both a social justice and mental health perspective, we are not treating the issues accurately and appropriately.

Introduction

The obesity epidemic is a major health problem, especially in disadvantaged and underserved communities. Obesity increases the risk of chronic health problems such as diabetes, heart disease and high blood pressure [2]. Nationwide, nearly 40% of adults and 20% of adolescents are obese [3]. In high-income countries, such as the United States, high rates of obesity are typically associated with lower education and income levels [4]. Furthermore, individuals in a lower socioeconomic class may not have access to nutritional foods, have less time to participate in physical activity and may only have access to more affordable higher calorie foods [4]. Earlier studies indicated that unemployment, poverty, and overall financial strain led to weight gain.

Food insecurity and food insu iciency

Approximately 37 million Americans live in households that are food insecure [5]. Food insecurity is defined as an inconsistent or lack of access to acquire enough food to meet the needs of a household due to insufficient access to money or other resources [6]. A construct related to food insecurity is food insufficiency, which is whether there is enough food to eat or the limited amount of food intake due to a lack of money or resources that gives access to enough food [7,8]. There is a significant overlap between the two. Individuals and families who experience food insufficiency often experience the most extreme levels of food insecurity [2,7].

The Supplemental Nutrition Assistance Program (SNAP) is a federal program to assist families in preventing food insecurity. To be eligible for SNAP benefits, a household without members who are disabled or elderly, one must have a monthly gross income at or below 130% of federal poverty guidelines [8]. To put it in perspective, in New York City, a family of 4 making$2100 a month is eligible for $479 dollars a month in food stamps. A single adult making $2100 a month is eligible for $20 dollars a month for food stamps (hungersolutions.org). This is based on an individual or head of household working fulltime at minimum wage, which in NYC is $15 dollars an hour. One cannot

imagine $479 dollars going very far in a month for a family of 4 in NYC or not $20 for an individual in NYC. People spend more than $20 on an individual meal in a restaurant.

Individuals and families that struggle with food insecurity and low socioeconomic status often live in urban areas and often live in what are called food deserts and food swamps. Food deserts are defined as areas that lack access to affordable and nutritious food [9]. Food swamps refer to urban areas that have a high concentration of inexpensive food retailers, such as fast-food restaurants and corner stores that sell highly processed foods that are high in fat, sugar and salt [10]. Limited access to healthier foods is a barrier to weight management and overall physical health.

Neighborhoods and food accessibility

In their systematic review discovered that many studies found a positive association between neighborhood food environments and higher BMI in neighborhoods with lower socioeconomic status [11]. Fast food restaurants and corner stores were the most assessed food environments related to obesity; however, the most consistent finding for the relationship between obesity and food environments was access to the corner store. Further studies have found that the more access one has to corner stores, the higher the BMI. However, there does not appear to be a positive correlation between a high BMI and access to fast food restaurants.

However, limiting access to a corner store to improve health outcomes is a much more complex issue. Here, in New York City, corner stores are affectionately referred to as “Bodegas”. A Bodega means ‘grocery store’ or ‘storeroom’ and became popular in the city after WWII with the influx of Hispanic immigrant communities [12]. Bodegas are typically open 24/7 and provide easy access to a bag of chips, a can of soda, a sandwich, or a bag of cookies. We must keep in mind that easy access to food is important in neighborhoods where many people may be working second or third shifts and typically at jobs that pay lower wages.

The Bodega was a way for immigrants to remain connected to their home country while finding a community in NYC. Bodegas provide a sense of community and Camaraderie of a small-town general store that many immigrants experience in their home country [12]. It has been suggested that there are between 8,000-14,000 in NYC across the five boroughs, although the health department recognizes only approximately 7,100. In a city that can feel so vast and unwelcoming, these corner stores, it should be argued, are essential in helping community members feel less isolated and more connected to their neighbors, which can be a helpful factor in decreasing the risk of depression.

Physical activity as a barrier to weight management

Several studies have suggested that a change in a built environment the addition of more accessible grocery stores or physical space for exercise-may positively impact health outcomes such as obesity and diabetes [13,14]. People living in communities have higher rates of poverty had higher exposure to neighborhood crime and violence [11]. This increased exposure has been linked to lower activity levels, which increases the risk of obesity [15]. Although parents may restrict the number of activities for their children based on safety and risk, research has found that parents will seek out alternative ways for a child to engage in physical activity outside of their community if the health of their child is at risk; however, a parent may not make the same efforts in regard to their own health and physical activity [16].

Studies have explored the effectiveness of lifestyle interventions, such as increased physical activity and dietary changes, in reducing binge-eating symptomology that leads to obesity [17,18]. Their findings show that subjects who participated in a physical activity group vs. a dietary change fared much better at reducing binge-eating behavior compared to the group that focused solely on dietary habits.

Fitness and dietary interventions

In New York State, Medicaid Manage Care insurance plans have recognized the benefit of offering access to physical exercise as a way of bringing down sky rocketing health care costs that are related to obesity and diabetes. Health first, a Medicaid Managed Care plan offers free gym memberships to its members. Their active and fit exercise program provides enrolled members the option to choose from a variety of fitness options, such as no-cost access to a participating fitness center or at home workouts using up to two out of 32 home fitness kits per year. As an added perk, they offer wearable fitness devices, such as the Apple watch, to track physical activity. Fideliscare, another Medicaid Manage Care company, offers partial gym membership reimbursement if the member has attended the gym at least 50 times in a six-month consecutive time frame (Fideliscare.org).

As mentioned earlier, studies have shown that physical activity has been a successful intervention at decreasing binge-eating behavior that often leads to obesity [17,18]. It should be further argued that this is an effective intervention because it leads to healthier affect regulation as well as creating an emotionally supportive community. This will be further discussed.

Supplemental nutrition assistance program

Federal food assistance programs such as SNAP have been shown to significantly reduce food insecurity. However, many SNAP users have reported difficulty in accessing affordable nutritious foods, such as fruits and vegetables and consumption is significantly below the recommendations in the Dietary Guidelines for Americans. Studies have found that SNAP participants consume more calories that are considered empty calories than higher income individuals but are still consuming fewer calories per day than their higher income counterparts [19]. Furthermore, it is estimated that 58% of beverages purchased in households receiving SNAP are sugar-sweetened drinks, such as soda [20]. Sugar-sweetened drinks have been positively associated with obesity and an increased risk of developing type II diabetes and cardiovascular disease [21].

There have even been calls to eliminate the ability to use SNAP benefits to purchase sugar-sweetened beverages [22]. Although restrictions on sugar-sweetened beverages have not been implemented for SNAP benefits, Mayor Mike Bloomberg banned the sale of sugary drinks over 16 ounces in restaurants in NYC in 2013 [23]. This was quickly struck down in the courts.

Health bucks

One approach to addressing these challenges is nutrition incentive programs, which are designed to improve access to fruits and vegetables among low-income populations by reducing the cost burden of these foods. New York City has implemented a program called health bucks as a way of addressing the obesity epidemic in impoverished communities. Nutrition incentive programs work by providing recipients with more purchasing power to be used on fresh produce. Health bucks is connected to the state's SNAP program. For every $2 spent at a farmers' market or green market, a participant will receive a $2 token to spend on fruits or vegetables at the market. This is a way of increasing access and affordability to nutritional food (grownnyc.org). It has this intervention been beneficial to low-income households? In 2020, over 600,000 health bucks worth more than $1,200,000 in fruits and vegetables were distributed (nycfoodpolicy.org).

This incentive program helped at reducing binge-eating or controlled rates of obesity? There are no studies to support that assumption. However, studies have shown the very opposite that adding fruits and vegetables to one's diet did not decrease binge-eating behavior [17,18]. Adding healthy foods or exercise to one's lifestyle to decrease obesity not only overly simplifies the issues but also disregards the mental health and emotional aspects of food consumption or lack thereof.

Disordered eating and eating disorder pathology

It has been suggested that the Supplemental Nutrition Assistance Program (SNAP) may play a role in the binge-eating, food-insufficient paradox [8]. There has been extensive research on food insecurity and disordered eating behaviors [6,7,24,25]. Research has shown that food insecurity is not significantly related to obesity but may increase the risk for disordered eating patterns, particularly binge-eating behavior [7]. It is suggested that fluctuations in food availability 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) [25].

It is important to note that restricting food consumption, whether voluntary or involuntary, leads to a preoccupation with food as well as an increased risk for binge eating behavior once the restrictions around food consumption are relaxed [6]. It has been found that the more severe the food insecurity is, the higher the risk for intentional food restriction [25]. According to restraint theory, intentionally restricting food intake increases the risk of binge eating [26].

It has been suggested that individuals living with food insecurity rarely reported the reason for restriction due to weight concerns or poor body image but rather restricted food to make food last or to save food for their children. However, food restriction is still correlated with eating disorder pathology [27]. Contrary to those findings found that individuals with severe food insecurity who also have children living in the home reported high rates of weight and shape concerns as well as high rates of compensatory behaviors such as purging, laxative abuse and obsessive exercising behavior [24]. As many as 17%-20% of those with food insecurity reported engaging in self-induced purging behavior as a means of controlling weight and body shape, especially after a binge-eating episode [24,25].

Family stress model and early trauma as predictors of eating disorder pathology

It is important to examine eating disorder pathology from a clinical perspective. Along with food insecurity, living in highly impoverished neighborhoods also comes with other challenges. As discussed earlier, poorer neighborhoods have higher crime rates [11] and higher rates of community violence. As research suggests, exposure to trauma in childhood and in adulthood increases the risk of a wide range of mental health issues across the life span [28]. Parents who have experienced trauma and PTSD have reported lower levels of parenting satisfaction, experience emotional numbing towards their children and have increased potential to abuse their children [29-31]. In addition, parents who have had exposure to trauma tended to perceive their child more negatively, perceive their child to be difficult to manage or report their interactions with their child to be disappointing [32]. Furthermore, parental distress and negative perceptions of children are associated with higher risks of child abuse and maltreatment [28]. This indicates that parental trauma may lead to impulsivity, parental anger and problems with emotion dysregulation [33].

Emotional neglect and emotional abuse explored

One can imagine that if a parent is struggling with his or her own mental health issues and is emotionally numb towards his or her children, there is a higher risk for adverse childhood experiences. Over the years, there has been a significant amount of research on the correlation of earlier childhood maltreatment and the development of eating disorders [34-36]. There is still not much that is understood regarding the impact of emotional neglect. It is estimated that 60% of children who have suffered from childhood maltreatment have experienced neglect (U.S. Department of Health and Human Services, Administration on Children, Youth and Families (ACYF), 2009).

Physical neglect is defined as the failure to adequately meet a child's basic needs for medical intervention, nutrition, clothing, supervision and personal hygiene [37]. Emotional neglect was defined by as the failure to meet the child's basic emotional needs, such as the need for adequate nurturance and affection, knowingly permitting maladaptive behavior or failure to seek out professional intervention for emotional or behavioral problems. The extent of child neglect is significant, finding that in the general population, the prevalence of physical neglect was

16.3% and 18.4% for emotional neglect. We can imagine that children living in impoverished communities and in homes with substantial financial hardships are at greater risk of emotional neglect and emotional abuse.

Emotional neglect and binge-eating disorder

It is important to explore the underlying issues of trauma as it relates to obesity and diabetes. As indicated above, earlier childhood trauma is a strong mediating factor in the development of an eating disorder. Emotional neglect is the most frequent trauma experienced in both men and women with binge-eating disorder, with 77.8% of females and 63.5% of males reporting EN [38]. It is suggested that this is much more significant than physical abuse or sexual abuse as the significant traumatic event. Other studies found similar findings with a sample of women with BED; 66% reported a history of emotional neglect and 52% emotional abuse, followed by 48%physical neglect [39]. Still significant were the 31% reporting sexual abuse and 28% reporting physical abuse.

In their meta-analysis, found that 50% of the participants had reported a childhood history of emotional neglect and/or physical neglect [35]. A similar prevalence of physical neglect ranged from 21% to 74%, and emotional neglect ranged from 33.3% to 69% in individuals with a clinical diagnosis of Eating Disorder (ED). Among the individuals studied, 57.36% had a diagnosis of eating disorder not otherwise specified EDNOS, 30.02% with Anorexia (AN) and 12.60% with Bulimia (BN)? This finding varies quite significantly with earlier studies, with the more prevalent diagnosis being either binge eating or bulimia. However, the diagnostic criteria for the samples assessed were from the DSM-IV before the diagnosis of binge-eating disorder was added.

Binge-eating disorder and bulimia nervosa

The DSM V now includes a category for Binge-Eating Disorder (BED) (APA, 2013). Recently, studies have investigated how earlier trauma is associated with Binge-Eating Disorders (BED) and obesity in adults [40]. One study revealed that a remarkable 80% of the participants who were obese reported one form of a childhood traumatic event [38]. Of the 35% of the sample found to have BED, there were significantly higher rates of trauma reported than the participants without BED. The trauma most associated with BED was emotional neglect and emotional abuse for both male and female participants. Females rated higher overall for all forms of trauma investigated, with emotional neglect being the highest reported form of earlier trauma experienced.

A history of abuse is significantly higher in individuals with EDs than in the general population and there has not been a significant correlation between childhood physical abuse or sexual abuse and the severity of eating disorder symptoms [41]. Emotional abuse is far more impactful than physical or sexual abuse, especially in individuals with BN, BED and obese individuals without BED [38,40], yet there still remains a positive correlation between physical abuse and all types of eating disorders [36].

However, the severity of emotional impairment is a far better indicator of the development of BED than the type of trauma itself [40]. Other research has shown a positive correlation between sexual abuse and both BN and BED but not a significant association between sexual abuse and anorexia nervosa [36]. It has also been suggested that eating pathology has a stronger association with lower levels of self-esteem than with childhood maltreatment [39].

There are similar results found in both clinical and non-clinical samples. The findings suggest that emotional abuse is consistently related to eating disorder symptoms. Binge eating was the highest reported symptom [42]. There is a significant correlation between the severity of eating disorder symptoms and emotional abuse, which is in line with the research, discussed thus far [41]. The overall prevalence of childhood trauma is up to 35% in the general population compared to a significantly higher rate of 21%-59% in individuals with any type of ED [34]. Further examination of research found a strong association of childhood trauma and eating disorders, particularly bulimia nervosa, binge-eating disorder, and anorexia nervosa, the binge-purge subtype, but not a positive correlation with anorexia nervosa, the restricting subtype. Further found that the earlier onset of childhood trauma, the more severe the ED symptomology leading to more binge-purge behavior more often compared to individuals who had no earlier childhood maltreatment. There seems to be a stronger connection to childhood trauma with bulimia nervosa and BED than any other ED [36].

It is important to note that obesity is not a DSM V diagnosis, but [40] found significant clinical pathology in individuals struggling with obesity. This is important for mental health clinicians to consider when assessing individuals with disordered eating habits that do not fall into the DSM V category of ED.

Emotion regulation

All forms of child abuse are positively correlated with deficits in emotional regulation and the development of ED [36,42]. Because neglected children had little experience with being soothed by their caregiver earlier in life, there is a distinct possibility that individuals do not have the ability to regulate intense emotional experiences and impulses [43]. It has been strongly suggested that bingeing, binging-purging and starvation are ways in which severely neglected and/or abused children are ways to regulate overwhelming affective states.

Mills, et al. [44] aimed to answer this complex issue by exploring whether emotion regulation is the mediating factor between emotional maltreatment, specifically emotional abuse and emotional neglect, and disordered eating. Their results showed a positive correlation between emotional abuse and emotion dysregulation, especially among the female sample. Furthermore, there was a high co-occurrence of both types of abuse, with 31.1% reporting a history of emotional neglect also having a history of emotional abuse, while 58% of those with reported histories of emotional abuse had scores indicating a history of emotional neglect. Finally, they found that emotional neglect was the strongest predictor of lower levels of emotional regulation.

Other studies support this finding, finding that the highest correlation of childhood trauma was with emotional neglect as a risk factor in developing eating disorders [45]. Earlier traumatic experiences and emotional dysregulation are significantly higher in people with eating disorders. Furthermore, they found that participants who had EDs generally had much more difficulty with emotion regulation.

Moulton, et al. [46] also explored the mediating factors of emotion regulation as well as dissociation for childhood abuse and eating pathology. They found, however, that the only form of trauma that was most significantly related to emotion regulation was emotional abuse. This was further supported in other studies showing that emotional abuse was most significantly correlated with emotion dysregulation, depression, and emotional eating [47]. It is unclear how pathological emotional eating was defined for this study. Most of the sample was unemployed at the time of the study, with almost 80% of the sample having a mean monthly income of less than $2000 and another 17% having a mean monthly income of less than $250. Additionally, it is important to note that most of the participants identified as African American. Poverty and racism were not explored as variables in this study, which could account for current levels of emotion dysregulation and emotional eating. Research does support that emotional neglect is the most significant form of childhood trauma, with 37.1% of the sample reported [46].

Racine and Wildes, et al. [48] hypothesized that childhood abuse is indirectly related to the severity of symptoms in anorexia nervosa through emotion dysregulation. They found that SA and EA were most positively correlated with emotion dysregulation and severity of AN symptomology, with the relationship of EA to emotion dysregulation being significantly greater than that of SA and emotion dysregulation. They concluded that EA was significantly correlated with eating pathology compared to PA or SA and that emotional dysregulation significantly mediates disordered eating relationships in individuals with a history of EA. Other research found a stronger correlation between early childhood trauma and severity of eating pathology but only in individuals with AN with a binge-purge subtype [34]. Rancine and Wildes, et al. [48] found no difference in AN subtype of restricting type or binge-purging type.

The role of emotion regulation needs further exploration as it relates to the development and maintenance of eating disorders. It has been suggested that eating disorders, either the use of binging or restricting, are a way to distract or regulate strong emotions [49]. Research has long supported the notion that individuals with eating disorders have an extreme amount of difficulty identifying and describing their feelings and emotions [50]. There is also the idea that individuals with eating disorders are unable to identify bodily sensations such as hunger and satiety and confuse these bodily sensations with emotions. It has been demonstrated that there is a strong association between alexithymia and eating disorders.

Assessment

Are we assessing minority clients thoroughly and accurately? I would argue not. This is of utmost concern. There are substantial psychiatric comorbidities associated with eating disorders [51]. Medical complications can be very serious and even life threatening while causing long-lasting damage to one's organ system [52]. Even faced with the seriousness of eating disorders, it remains both underdiagnosed and undertreated, with only one-third of individuals struggling with eating disorders ever receiving treatment [53].

It has been suggested that the failure for those who need treatment to receive it is likely due to the perceived need for treatment due to race or ethnicity or for those who are obese [54]. Returning to this claim found that of college-age subjects with symptoms of eating disorders, only 10.5% had received a diagnosis and only 13.6% of those received treatment in the past year. As expected, those who had a diagnosis and received treatment within the past year struggled with symptoms associated with anorexia and were more likely females over their male counterparts. They also found that the perceived need for treatment was more associated with individuals from more affluent backgrounds.

I am the director of a community-based metal health clinic in East Harlem, New York. East Harlem is one of the poorest neighborhoods in New York City, with 31% of the residents living below the poverty level (NYC Department of Health and Mental Hygiene, 2015). An alarming 33% of adults in this community are considered obese, with another 13% diagnosed with diabetes (NYC Department of Health and Mental Hygiene, 2015). Life expectancy in this community is 76 years old, with the leading causes of death being heart disease in number one and diabetes in number three (NYC Department of Health and Mental Hygiene, 2015). As we explored in this article, eating disorders are not a phenomenon specific to white affluent young women. Trauma and poverty increase the risk of disordered eating. A majority of clients coming into the clinic suffer from some form of trauma, whether it is childhood trauma, community violence or systematic racism, or all of the above. A significant portion of the community served is supported by food stamps and suffers from food insecurity. However, until this past year, we were not assessing eating disorders or even exploring eating patterns. We assessed tobacco use and substance use, both I would argue, is used for emotion regulation. We assessed a history of trauma within the family dynamic as well as current daily stressors. We ensure that we understand the full picture of the clients through a three-part intake process with an intake therapist and a full psychiatric evaluation, yet we are not assessing for eating disorders or even eating pathology.

Before taking on the directorship role in the clinic, I was a clinical supervisor who carried a full case load and due to a lot of our clients having longevity at the clinic, most of the clients, I inherited from other therapists. Many of these clients were struggling with eating disorders but had never been assessed or diagnosed with an eating disorder. Numerous studies have found that eating disorders are often unrecognized in clinical settings [55-57]. Further research suggests that even when

eating disorder symptoms are recognized, appropriate care is not initiated [58,59].

Case examples

One of my clients, a middle age African American woman, was tormented by her eating disorder. She would starve herself for three days at a time and then binge eat. She was full of such shame and guilt around this behavior. But until we started talking about it, she suffered in silence. She reported that when she was a teenager, she was anorexic. No one seemed to notice. This woman had a severe history of physical abuse, emotional abuse and emotional neglect by her mother.

Another client, a black woman in her late 50's, suffered from anorexia. She had lost a significant amount of weight, 50 pounds, in a relatively short amount of time. She complained of dizziness but was diagnosed with vertigo rather than anorexia. Earlier studies reflect this bias, finding that clinicians were able to recognize eating disorder symptoms when a case scenario was presented as white, Hispanic and black but were less likely to give a diagnosis of an eating disorder or recommend treatment when the client was black [60,61].

Not one of these clients carried a diagnosis of an eating disorder. This should be very concerning for clinicians. If we are not assessing someone fully for pathological behaviors and distorted feelings, we are not treating them appropriately or properly. Even after implementing a section in the initial comprehensive assessment, I noticed that many clinicians are skipping that section in the intake process, or if they have identified distorted eating patterns, it is not reflected either in a diagnosis or even further explored. I don't believe that the therapists at my clinic are inept; rather I believe this is an issue on a much broader scale.

The Office of Mental Health (OMH), which regulates all mental health clinics and facilities in New York State, requires a screening for tobacco use and substance use. Of course, these assessments are important; tobacco, alcohol and abuse of substances are killing people. But as I pointed out, so are diabetes and hypertension, especially in poorer communities. OMH is concerned with the rates of obesity and diabetes; we are required to report that in our demographic data for the state. However, that is where the concern or curiosity around health, the causes and connections to these problems ceases.

Racial stereotypes

Giving access to healthier foods isn't the answer. As I see it, that is equivalent to telling someone who suffers from anorexia to just go eat a meal. That is not solving the deeper problem. My client who struggled with the cycle of restriction and binge eating was ultimately told by her doctor to see a nutritionist. To further add insult to injury, when this client told her doctor she was having severe stomach pains, he told her just to eat regular meals. Stomach pain occurred when this woman starved for three days at a time. She knew intellectually what foods were healthy for her and she also knew that the restricting/binge-purge pattern of behavior was unhealthy. So why not just change behavior? Certainly, this doctor felt that seeing a nutritionist would solve the issue. The simple answer is that she struggles with an eating disorder that is deeply connected to her history of severe abuse. Therefore, the appropriate intervention is not food education but rather mental health treatment for both trauma and an eating disorder.

A recent study found that African American women use unhealthy weight control behaviors such as fasting, laxative use, eating very little, or made themselves purge more than any other racial group, especially in adulthood [62-65]. So, the doctor that advised my client to "just eat", minimized the drastic extremes this woman went through and the potential damage the severe restriction was doing to her internally. It also minimized the deeper issues around abuse, self-loathing, or the overwhelming feelings of emotional pain. Ultimately, it repeated the pattern of emotional neglect and reinforced the idea that she is not worth being cared for, even by the very people who are tasked to do so.

As research supports, clients feel demoralized and frustrated by racially based stereotypes that mental health clinicians have around eating disorders [66]. Research also suggests that barriers to treatment may lie with the racial stereotypes of the clinician, finding that minority patients are less likely than their white counterparts to be asked by a physician about eating disorder symptoms and be less likely to be referred for further mental health treatment [67-71]. Furthermore, many individuals with BED have been more likely to be referred to weight loss programs than for the treatment of eating disorders [72-76]. Many individuals with BED express the desire to lose weight as well as the desire to stop eating behavior; however, most have used dieting only as a form of intervention and most individuals have never been in mental health treatment for their eating disorder [77,78].

Conclusion

It is important that we further explore the implications of being poor in this country. Ultimately, it appears that not having enough food may be directly related to the obesity epidemic, which directly results in astronomical health care costs related to diabetes, especially in marginalized communities. We, as social workers, need to rethink the approach to public health and finally address the issues around food insecurity and food insufficiency. This ultimately will lower health care costs and support healthier living.

More importantly, we need to address the issues around eating disorders from a trauma-informed lens with a better clinical understanding that eating disorders do not just impact young affluent white women. More research needs to be done on if and why clinicians are assessing people of color for eating disorders so we can better treat people for their mental health issues, especially issues that stem from systematic trauma. 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.

Declarations

Data sharing is not applicable to this article, as no datasets were generated or analysed during the current study.

Competing Interests

The authors declare that they have no competing interests.

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