CALIFORNIA AREA INDIAN HEALTH SERVICE
Project ECHO®

Approaching Eating Disorders with Cultural Humility

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August 11, 2022

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Introducing the Presenter

Steven Sust is the middle child of 3 boys born to Hong Kong immigrant parents who raised them in downtown Philadelphia. He received a bachelor's degree in psychology from GWU, medical degree from UVA, and postgraduate training at UPenn and Stanford. His work experiences range broadly from state psychiatric hospitals, county specialty MH clinics and emergency rooms to school mental health and schizophrenia research at NIMH. Current interests include primary care behavioral health integration, cultural psychiatry, school mental health, and working with underserved populations.

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Personal Disclosures

- I am a cisgender male of Cuban influenced Chinese descent
- I have no formally diagnosed family history of mental illness
- I have sought out and received my own mental health care
- I have both knowingly and unknowingly contributed to bias and most “isms,” and will try to improve upon these areas of growth

Learning objectives

- Recognize attitudes/statements that affect youth body image and positivity
- Identify Eating Disorder screening and intervention methods in primary care settings
- Acquire new knowledge regarding cultural and psychosocial stressors affecting Eating Disorders that requires close collaboration between clinicians, schools, parents, and youth

Context and Humility

"To be fully culturally competent, practitioners should understand the meaning of the NA/AI experience by understanding that, collectively, Native people have been wounded through the processes of genocide, removal, assimilation, acculturation, and loss of culture."

Link to article "Correlates and Predictors of Binge Eating Among Native American Women"

Imperfect Epidemiology Data

Behavioral Symptoms of Eating Disorders in Native Americans: Results from the Add Health Survey Wave III

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ABSTRACT

Objective: To examine prevalence and correlates (gender, Body Mass Index) of disordered eating in American Indian/Native American (AI/NA) and white young adults.

Method: We examined data from the 10,334 participants (mean age 21.93 years, SD = 1.8) of the National Longitudinal Study of Adolescent Health (ADD Health) Wave III for gender differences among AI/NA participants (236 women, 253 men) and ethnic group differences on measures of eating pathology.

Results: Among AI/NA groups, women were significantly more likely than men to report loss of control and embarrassment due to overeating. In gender-stratified analyses, a significantly higher prevalence of AI/NA women reported disordered eating behaviors compared with white women; there were no between group differences in prevalence for breakfast skipping or having been diagnosed with an eating disorder. Among men, disordered eating behaviors were uncommon and no comparison was statistically significant.

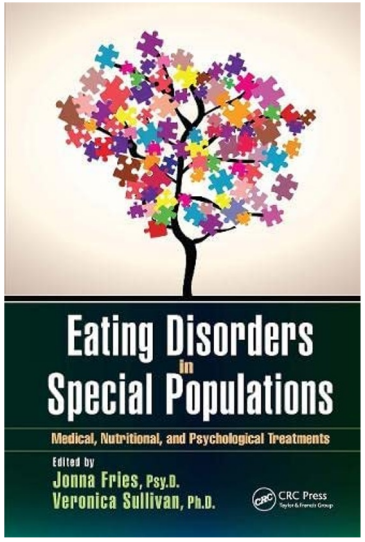
Discussion: Our study offers a first glimpse into the problem of eating pathology among AI/NA individuals. Gender differences among AI/NA participants are similar to results reported in white samples. That AI/NA women were as likely as white women to have been diagnosed with an eating disorder is striking in light of well documented under-utilization of mental health care among AI/NA individuals.

Keywords: eating disorder; Native American; ethnicity; gender differences

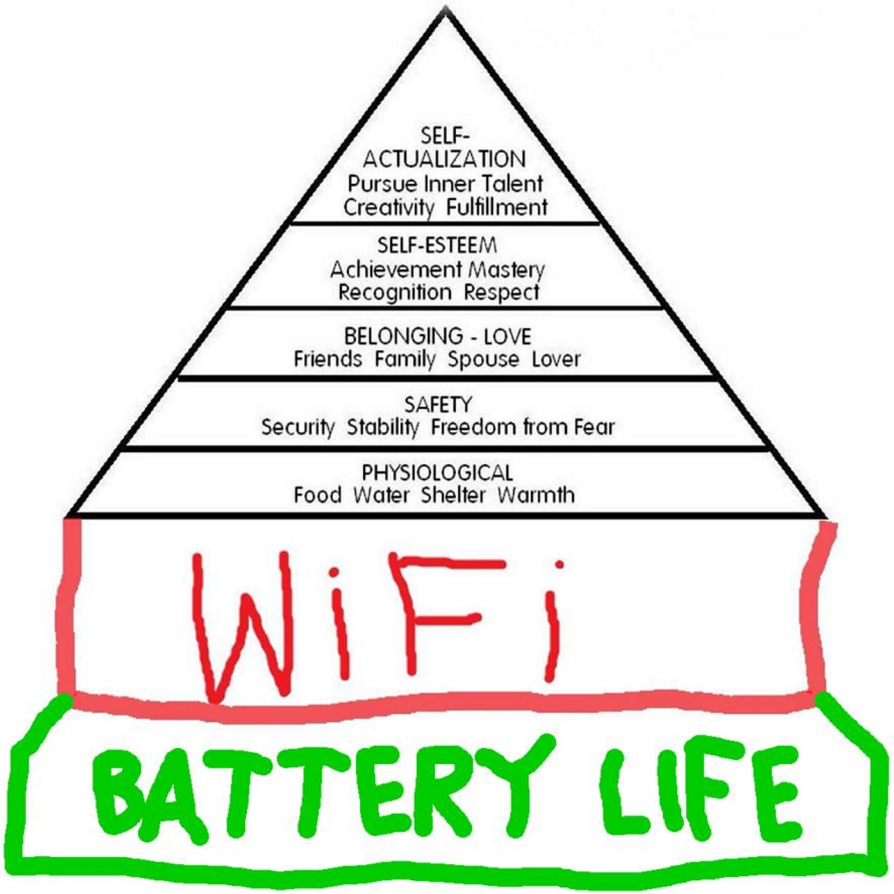
(Int J Eat Disord 2011; 44:561–566)

https://doi.org/10.1002/eat.20894 | Link to Article

Link to Book



Starting From a Humanistic Perspective



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Informing Family Approaches to Eating Disorder Prevention: Perspectives of Those Who Have Been There

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ABSTRACT

Objective: The study explored how aspects of the family environment may relate to the onset of eating disorders.

Method: Semi-structured interviews were conducted with 27 individuals currently receiving treatment for eating disorders. Data were analyzed using principles of content analysis.

Results: Eight themes emerged regarding recommendations for families to prevent the onset of eating disorders: (1) Enhance parental support; (2) Decrease weight and body talk; (3) Provide a supportive home food environment; (4) Model healthy eating habits and physical activity patterns; (5) Help your children build self-esteem beyond looks and physical appearance; (6) Encourage appropriate expression of feelings and use of coping mechanisms; (7) Increase your understanding of eating disorder signs and symptoms; and (8) Gain support in dealing appropriately with your own struggles.

Discussion: Our results can be utilized to generate new theoretical insights as to how parents can raise children with healthy weight-related attitudes and behaviors.

Keywords: adolescents; eating disorders; prevention; families; home environment; anorexia nervosa; bulimia nervosa

(Int J Eat Disord 2009; 42:146–152)

Link to article

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Preventing Obesity and Eating Disorders in Adolescents

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https://doi.org/10.1542/peds.2016-1649 | Link to Article

Risk Management Strategies In Teens

1. Dieting, defined as caloric restriction with the goal of weight loss, is a risk factor for both obesity and EDs
2. Family meals have been associated with improved dietary intake and provide opportunities for modeling behavior by parents, even though family meals have not been shown to prevent obesity across ethnic groups

https://doi.org/10.1542/peds.2016-1649 | Link to Article

Strategies(Continued)

3. Weight talk by family members refers to comments made by family members about their own weight or comments made to the child by parents to encourage weight loss. Even well-intended comments can be perceived as hurtful by the child or adolescent.

https://doi.org/10.1542/peds.2016-1649 | Link to Article

Strategies(Continued)

4. Family weight teasing predicts the development of overweight status, binge eating, and extreme weight-control behaviors in girls and overweight status in boys.

https://doi.org/10.1542/peds.2016-1649 | Link to Article

Strategies(Continued)

5. Body dissatisfaction is a known risk factor for both EDs and disordered eating; higher scores of body dissatisfaction are associated with more dieting and unhealthy weight-control behaviors in both boys and girls, reduced physical activity in girls, and more binge eating in boys

https://doi.org/10.1542/peds.2016-1649 | Link to Article

Goals to Aspire Towards

1. Eat intuitively: when you are hungry, eat. When you are full, stop eating.
2. No restricting, dieting, or calorie counting
3. Choose meals that you enjoy, and that you digest comfortably
4. Wear clothes that you like and that feel comfortable
5. Mute or unfollow social media accounts that make you feel a type of way about your body
6. Exercise to feel good, not to lose weight
7. Pick exercises that you enjoy doing
8. Neutrally acknowledge how your body functions well: "my legs can walk around the neighborhood" "my brain can solve math problems"
9. Acknowledge how your body may not work well without shame: "I cannot lift heavy things" "my body does not digest dairy"
10. Do not comment on others bodies

Link to above UW resource on body neutrality

Empathy and Support

STEPS TO MIRRORING

Practice **mirroring** using sentence stems and avoid **empathy blockers** - well intentioned statements that may communicate judgment by shifting the attention away from the person who needs to be heard.

MIRRORING SENTENCE STEMS

IT SOUNDS LIKE YOU ARE FEELING...

I'M HEARING YOU SAY THAT YOU...

I WONDER IF YOU FEEL...

IT SEEMS LIKE YOU ARE NEEDING...

COMMON EMPATHY BLOCKERS

SILVERLINING IT

Reassuring, cheering up, downplaying, trying to make them feel better or differently

FIXER UPPER

Offering your solutions, advice, beliefs, or opinions

INTERROGATING

Probing, analyzing, evaluating

TABLE 3 High-Risk Eating and Activity Behaviors and Clinical Findings of Concern

High-risk eating and activity behaviors

- Severe dietary restriction (<500 kcal/d)
- Skipping of meals to lose weight
- Prolonged periods of starvation
- Self-induced vomiting
- Use of diet pills, laxatives, or diuretics
- Compulsive and excessive exercise
- Social isolation, irritability, profound fear of gaining weight, body image distortion

Clinical findings of concern

- Rapid weight loss
- Falling off percentiles for weight and BMI
- Amenorrhea in girls
- Presence of vital sign instability
  - o Bradycardia (heart rate <50 beats/minute during the day)
  - o Hypotension (<90/45 mm Hg)
  - o Hypothermia (body temperature <96°F [<35.6°C])
  - o Orthostasis (increase in pulse >20 beats/min) or decrease in blood pressure (>20 mm Hg systolic or >10 mm Hg diastolic) on standing

https://doi.org/10.1542/peds.2016-1649 Link to Article

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

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Identification and Management of Eating Disorders in Children and Adolescents

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CALIFORNIA AREA INDIAN HEALTH SERVICE
Project ECHO®

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TABLE 1 Diagnostic Features of Eating Disorders Commonly Seen in Children and Adolescents

DSM-5 Eating Disorder Diagnosis	Diagnostic Features
Anorexia nervosa (AN)	A. Restricted caloric intake relative to energy requirements, leading to significantly low body weight for age, sex, projected growth, and physical health B. Intense fear of gaining weight or behaviors that consistently interfere with weight gain, despite being at a significantly low weight C. Altered perception of one's body weight or shape, excessive influence of body weight or shape on self-value, or persistent lack of acknowledgment of the seriousness of one's low body weight Subtypes: restricting type (weight loss is achieved primarily through dieting, fasting, and/or excessive exercise. In the previous 3 mo, there have been no repeated episodes of binge eating or purging); binge-eating/purging type (in the previous 3 mo, there have been repeated episodes of binge eating or purging; ie, self-induced vomiting or misuse of laxatives, diuretics, or enemas)
Bulimia nervosa (BN)	Repeated episodes of binge eating. Binge eating is characterized by both of the following: within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time under similar circumstances and a sense that one cannot limit or control their overeating during the episode Repeated use of inappropriate compensatory behaviors for the prevention of weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise On average, the binge eating and compensatory behaviors both occur at least once a week for 3 mo Self-value is overly influenced by body shape and weight The binge eating and compensatory behaviors do not occur exclusively during episodes of AN
Binge-eating disorder (BED)	Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time under similar circumstances and sense that one cannot limit or control their overeating during the episode The binge-eating episodes include 3 or more of the following: eating much more quickly than normal, eating until uncomfortably full, eating large amounts of food when not feeling hungry, eating alone because of embarrassment at how much one is eating, and feeling guilty, disgusted, or depressed afterward Marked anguish is experienced regarding binge eating On average, the binge eating occurs at least once a week for 3 mo The binge eating is not associated with the use of inappropriate compensatory behavior as in BN and does not occur only in the context of BN or AN
Avoidant/restrictive food intake disorder (ARFID)	A disrupted eating pattern (eg, seeming lack of interest in eating or food; avoidance based on the sensory qualities of food; concern about unpleasant consequences of eating) as evidenced by persistent failure to meet appropriate nutritional and/or energy needs associated with 1 (or more) of the following: significant weight loss or, in children, failure to achieve expected growth and/or weight gain, marked nutritional deficiency, reliance on enteral feeding or oral nutritional supplements, significant interference with psychosocial functioning The disturbance cannot be better explained by lack of available food or by an associated culturally sanctioned practice The eating disturbance cannot be attributed to a coexisting medical condition nor better explained by another mental disorder. If the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder
Other specified feeding or eating disorders, examples	Atypical AN: all of the criteria for AN are met yet the individual's weight is within or above the normal range despite significant weight loss BN (of low frequency and/or limited duration): All of the criteria for BN are met, but, on average, the binge eating and compensatory behaviors occur less than once a week and/or for <3 mo BED (of low frequency and/or limited duration): All of the criteria for BED are met, but, on average, the binge eating occurs less than once a week and/or for <3 mo Purging disorder: recurrent purging behavior (eg, self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating with the intent to influence weight or body shape

Adapted from the *DSM-5*, American Psychiatric Association, 2013.[2]

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Eating Attitudes Test© (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: ..... Day: ..... Year: ..... 2) Gender: ❑ Male ❑ Female

3) Height Feet: ..... Inches: .....

4) Current Weight (lbs.): ..... 5) Highest Weight (excluding pregnancy): .....

6) Lowest Adult Weight: ..... 7) Ideal Weight: .....

	Part B: Please check a response for each of the following statements:	Always	Usually	Often	Sometimes	Rarely	Never
1.	Am terrified about being overweight.	❑	❑	❑	❑	❑	❑
2.	Avoid eating when I am hungry.	❑	❑	❑	❑	❑	❑
3.	Find myself preoccupied with food.	❑	❑	❑	❑	❑	❑
4.	Have gone on eating binges where I feel that I may not be able to stop.	❑	❑	❑	❑	❑	❑
5.	Cut my food into small pieces.	❑	❑	❑	❑	❑	❑
6.	Aware of the calorie content of foods that I eat.	❑	❑	❑	❑	❑	❑
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	❑	❑	❑	❑	❑	❑
8.	Feel that others would prefer if I ate more.	❑	❑	❑	❑	❑	❑
9.	Vomit after I have eaten.	❑	❑	❑	❑	❑	❑
10.	Feel extremely guilty after eating.	❑	❑	❑	❑	❑	❑
11.	Am preoccupied with a desire to be thinner.	❑	❑	❑	❑	❑	❑
12.	Think about burning up calories when I exercise.	❑	❑	❑	❑	❑	❑
13.	Other people think that I am too thin.	❑	❑	❑	❑	❑	❑
14.	Am preoccupied with the thought of having fat on my body.	❑	❑	❑	❑	❑	❑
15.	Take longer than others to eat my meals.	❑	❑	❑	❑	❑	❑
16.	Avoid foods with sugar in them.	❑	❑	❑	❑	❑	❑
17.	Eat diet foods.	❑	❑	❑	❑	❑	❑
18.	Feel that food controls my life.	❑	❑	❑	❑	❑	❑
19.	Display self-control around food.	❑	❑	❑	❑	❑	❑
20.	Feel that others pressure me to eat.	❑	❑	❑	❑	❑	❑
21.	Give too much time and thought to food.	❑	❑	❑	❑	❑	❑
22.	Feel uncomfortable after eating sweets.	❑	❑	❑	❑	❑	❑
23.	Engage in dieting behavior.	❑	❑	❑	❑	❑	❑
24.	Like my stomach to be empty.	❑	❑	❑	❑	❑	❑
25.	Have the impulse to vomit after meals.	❑	❑	❑	❑	❑	❑
26.	Enjoy trying new rich foods.	❑	❑	❑	❑	❑	❑

Link to

Collaborating on Testing and Workup

TABLE 4 Selected Differential Diagnosis for Eating Disorders According to Presentation

Clinical Presentations	Differential Diagnosis
Weight loss	
Gastrointestinal	Inflammatory bowel disease; celiac disease
Endocrine	Hyperthyroidism; diabetes mellitus; adrenal insufficiency
Infectious	Chronic infections, such as tuberculosis or HIV; intestinal parasite
Psychiatric	Depression; psychosis; anxiety or obsessive-compulsive disorder; substance use
Other	Neoplasm; superior mesenteric artery syndrome
Vomiting	Gastroesophageal reflux disease
Gastrointestinal disease	Gastroesophageal reflux disease
	Eosinophilic esophagitis
	Pancreatitis
	Cyclic vomiting
Neurologic	Increased intercranial pressure
	Migraine
Other	Food allergy
Binge eating or unexplained weight gain	
Endocrine	Hypothyroidism; hypercortisolism
Psychiatric	Depression
Iatrogenic	Medication side effect
Genetic	Prader Willi syndrome; Kleine-Levin syndrome

Adapted from Rome and Strandjord[89] and Rosen; American Academy of Pediatrics.[208]

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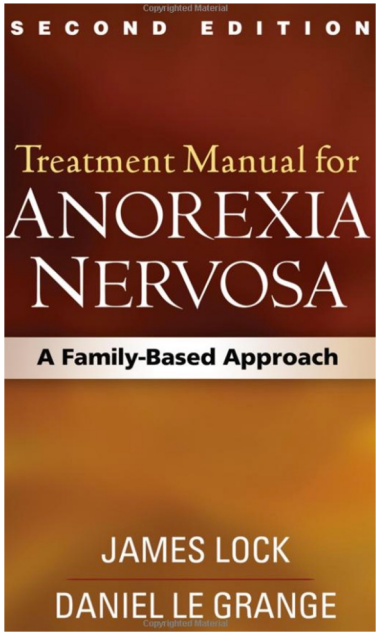
Integrated Care

"Patients with mild nutritional, medical, and psychological dysfunction may be managed in the pediatrician's office in collaboration with outpatient nutrition and mental health professionals with specific expertise in eating disorders."



Link to Stanford studies on Webinar versus Online Training for FBT Anorexia

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TABLE 6 Indications Supporting Hospitalization in an Adolescent With an Eating Disorder

One or More of the Following Justify Hospitalization
1. ≤75% median BMI for age and sex (percent median BMI calculated as patient BMI/50th percentile BMI for age and sex in reference population × 100)
2. Dehydration
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
4. ECG abnormalities (eg, prolonged QTc or severe bradycardia)
5. Physiologic instability:
a. Severe bradycardia (HR <50 beats per min daytime; <45 beats per min at night);
b. Hypotension (90/45 mm Hg);
c. Hypothermia (body temperature <96°F, 35.6°C);
d. Orthostatic increase in pulse (>20 beats per min) or decrease in BP (>20 mm Hg systolic or >10 mm Hg diastolic)
6. Arrested growth and development
7. Failure of outpatient treatment
8. Acute food refusal
9. Uncontrollable binge eating and purging
10. Acute medical complications of malnutrition (eg, syncope, seizures, cardiac failure, pancreatitis and so forth)
11. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (eg, severe depression, suicidal ideation, obsessive-compulsive disorder, type 1 diabetes mellitus)

Reprinted with permission from the Society for Adolescent Health and Medicine.[85] ECG, electrocardiogram.

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Summary

1. Our words and actions can be powerful when communicating with youth about body image
2. Consider setting up Integrated Care workgroup with cultural practitioner at your site to discuss early identification/screening for eating disorders
3. Be familiar with slide #17("High Risk Eating and Activity Behaviors and Clinical Findings of Concern")

References

Please see direct URL links embedded in slides

Presenter Contact Information

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