Approaching Eating Disorders with Cultural Humility

Steven Sust, MD
Clinical Assistant Professor
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The views expressed in this presentation are those of the speaker and do not necessarily represent the views, policies, and positions of the Indian Health Service (IHS), or the U.S. Department of Health and Human Services (HHS).
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.

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.”
Imperfect Epidemiology Data

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

Ruth H. Stieglitz-Moore, PhD1,2,3
Francesca Roselli, PhD2
Niki Holtzman, BA1
Lisa Dietiker, PhD1
Anne E. Becker, MD, PhD, ScM1,4
Cyda Swaney, PhD5

ABSTRACT

Objective: To examine prevalence and correlates (gender, body mass index of disordered eating in American Indian/ Native American (AI/AN) and white adults.

Method: We examined data from the 10,344 participants (mean age 21.95 years, SD = 5.6) of the National Longitudinal Study of Adolescent Health (Add Health) Wave III for gender differences among AI/AN participants (27% women, 25% men) and ethnic group differences on measures of eating pathology.

Results: Among AI/AN groups, women were significantly more likely than men to report loss of control and preoccupation due to overeating, in gender-stratiﬁed analysis, a signiﬁcantly higher prevalence of AI/AN women reported disordered eating behaviors compared with white women; there were no between-group differences in prevalence for binge eating 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/AN individuals. Gender differences among AI/AN participants are similar to results reported in white samples; that AI/AN women are as likely as white women to have been diagnosed with an eating disorder is striking in light of well documented underutilization of mental health care among AI/AN individuals. © 2011 by Wiley Periodicals, Inc.

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

(String Eat Disord 2011; 44:561–564)

Starting From a Humanistic Perspective
Informing Family Approaches to Eating Disorder Prevention: Perspectives of Those Who Have Been There

Katie A. Loth, MPH\textsuperscript{1}\textsuperscript{*}
Dianne Neumark-Sztainer, PhD, MPH, RD\textsuperscript{1}
Jillian K. Croll, PhD, MPH, RD\textsuperscript{2}

\textbf{ABSTRACT}

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

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

\textbf{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.

\textbf{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. © 2008 by Wiley Periodicals, Inc.

\textbf{Keywords:} adolescents; eating disorders; prevention; families; home environment; anorexia nervosa; bulimia nervosa

\textit{Int J Eat Disord.} 2009; 42:146–152

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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

Neville H. Golden, MD, FAAP, Marcie Schneider, MD, FAAP, Christine Wood, MD, FAAP,
COMMITTEE ON NUTRITION, COMMITTEE ON ADOLESCENCE, SECTION ON OBESITY

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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

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

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.
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.

Empathy and Support

STEPS TO MIRRORING

01 LISTEN CAREFULLY AND ATTENTIVELY
02 IMAGINE THEIR PERSPECTIVE AND FEELINGS
03 STAY OUT OF JUDGMENT (AVOID BLOCKERS)
04 PARAPHRASE THEIR FEELINGS AND PROBLEMS

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
  - Bradycardia (heart rate ≤50 beats/minute during the day)
  - Hypotension (<90/45 mm Hg)
  - Hypothermia (body temperature <96°F [<35.6°C])
  - Orthostasis (increase in pulse >20 beats/min) or decrease in blood pressure (>20 mm Hg systolic or >10 mm Hg diastolic) on standing

Identification and Management of Eating Disorders in Children and Adolescents

Laurne L. Hornberger, MD, MPH, FAAP®, Margie A. Lane, MD, FAAP®, FAAP® THE COMMITTEE ON ADOLESCENCE

CLINICAL REPORT  Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
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: __________ Gender: [ ] Male [ ] Female
2) Height: __________ Feet: __________ Inches: __________
3) Current Weight (lbs.): __________
4) Highest Weight (excluding pregnancy): __________
5) Lowest Adult Weight: __________
6) Ideal Weight: __________

Part B: Please check a response for each of the following statements:

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

<table>
<thead>
<tr>
<th>Clinical Presentations</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Inflammatory bowel disease; celiac disease</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Hyperthyroidism; diabetes mellitus; adrenal insufficiency</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Chronic infections, such as tuberculosis or HIV; intestinal parasites</td>
</tr>
<tr>
<td>Infectious</td>
<td>Depression; psychosis; anxiety or obsessive-compulsive disorder; substance use</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Nephrolithiasis; superior mesenteric artery syndrome</td>
</tr>
<tr>
<td>Other</td>
<td>Gastroesophageal reflux disease</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Gastroesophageal reflux disease</td>
</tr>
<tr>
<td>Gastrointestinal disease</td>
<td>Esophagogastroduodenitis</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Pancreatitis</td>
</tr>
<tr>
<td>Other</td>
<td>Cyclic vomiting</td>
</tr>
<tr>
<td>Inadequate weight gain</td>
<td>Increased intracranial pressure</td>
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<tr>
<td>Endocrine</td>
<td>Migraine</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Food allergy</td>
</tr>
<tr>
<td>Inorganic</td>
<td>Hypothyroidism; hypoadrenalism</td>
</tr>
<tr>
<td>Genetic</td>
<td>Depression</td>
</tr>
<tr>
<td>Other</td>
<td>Medication side effect</td>
</tr>
<tr>
<td>Other</td>
<td>Prader-Willi syndrome; Klippel-Feil syndrome</td>
</tr>
</tbody>
</table>

Adapted from Rame and Strand.® and Rees; American Academy of Pediatrics.®

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.”
**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
Steven Sust, MD
susts@stanford.edu