

Science & Society

From disparities to equity: striving for more in our treatments for feeding and eating disorders

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Adopting a framework of equity is urgently needed to reduce disparities persistent in feeding and eating disorder (FED) treatment models. This framework must emphasize the exchange of knowledge between relevant stakeholders and implementation strategies to impact practice and embrace a systemic change in the FED field.

FEDs are common psychiatric illnesses and are associated with high mortality rates [1]. Lifetime prevalence of experiencing a FEDs by age 40 years is estimated at 14.3% in men and nearly 20% in women [1]. Historically, much of the research in the field has focused on one specific FEDs (e.g., anorexia nervosa) and has included randomized clinical trial (RCT) samples with people identifying mostly as White, cisgender women [2]. Although the prevalence of FED is similar among racial and ethnic groups, as compared to non-Latino White participants [2,3], the service utilization in diversity population is significantly lower [2]. For example, mental health service utilization with a lifetime history of any eating disorder was 75.8% for non-Latino Whites versus 61.65% for Latinos, 63.22% for Asian Americans, and 62.21% for African Americans [2].

Factors maintaining inequities in treatment of FEDs

Several factors have contributed to maintaining the inequities in access to treatment of FEDs. To begin, the current framework for FEDs reflects the experiences of western and white society [4]. The fact that most of the research and clinical trials, including genetic studies are conducted primarily with English-speaking participants and White women [5], help to maintain the belief that FEDs look a specific way (White, female, thin, high socioeconomic status), and with a profile that does not necessarily reflect the concerns and needs of members of diverse populations.

The current assessment and diagnostic tools, as well as the limited research about how marginalized communities might experience eating disturbances and body dissatisfaction (i.e., skin color, hair texture, facial features) also perpetuate the narrowed look of FEDs. These results have led to the inaccurate conclusion that members from marginalized populations may be protected from FEDs and/or do not experience body image concerns [6].

Consequently, there is an urgent call to reverse the history of bias in a more proactive manner and with accountability [7]. Without a different framework, the field will continue to replicate systems that do not consider the nuances of diverse cultural backgrounds and the multiple social identities that members from diverse and marginalized populations encounter [8].

Centering a framework of equity in FEDs treatment

A recent study [7] issued a striking call to center our focus on moving to equity and increase accountability in FED leadership and research to enhance racial/ethnic justice and diversity in this field. The authors critically acknowledge that bold strategies to recruiting and retaining under-represented researchers in the field of FEDs will be critical to success. We extend this work by calling

for a framework of equity in the approach to reducing disparities persistent in FED treatment. Adopting a framework of equity, defined as transitioning from placing the emphasis on what we are doing poorly to what we can achieve, would position the FEDs field to make movement toward seeing the change that is possible in our treatment programs and research [9]. Incorporating this focus would require an extended focus on the needs, culture, and communities that have been underserved, as well as critical analyses of systems and policies where inequities may arise [9]. Shifting our focus on achieving equity in our access to treatments for FEDs will require a road map (Figure 1); particularly one that will provide signposts on ways to exchange knowledge between relevant stakeholders and necessary actions that will impact practice so we can embrace a systemic change in the FEDs field. Below, we provide helpful tools that have been adapted from the knowledge-to-action framework [10], and from implementation science [11], to guide the process.

As a first step, it would be critical to include important stakeholders with established roles at the outset of the discussion and be intentional working with those who have been marginalized and/or uninvolved to have the largest voice in the creation of programs that would ultimately serve them. Indeed, collaborative research that centers the needs and voices of those with lived experience may be one of the fastest tools to generate a greater impact on policy and treatment programs to improve treatments for FEDs [12]. Certainly, once those with the lived experience of marginalization are 'brought to the table', there will be increasing opportunities to build new treatment models that may fit their needs better than the current model. Shifting to a process of cocreation with stakeholders will help to (i) identify the social determinants of health that influence FEDs treatment outcomes; and (ii) design treatments models that may be aligned with community needs at the outset [9,11].

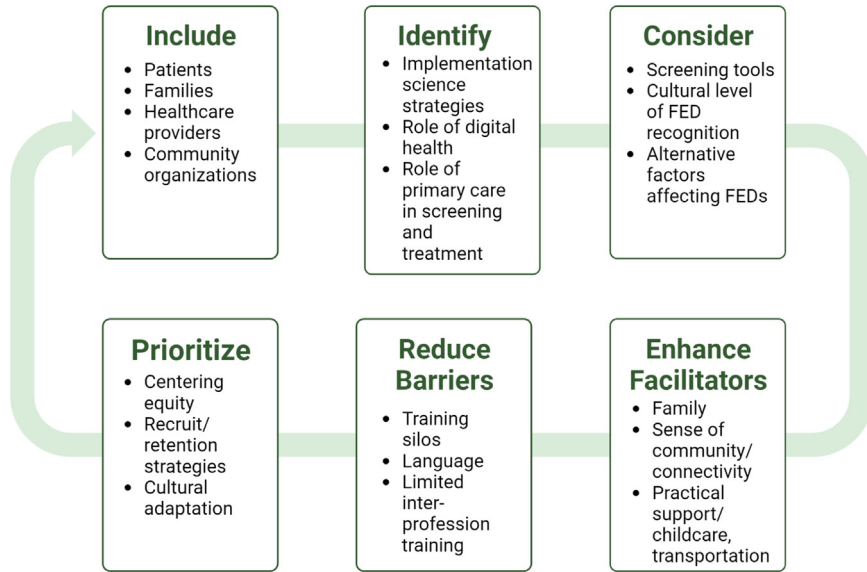


Figure 1. Framework for centering equity in feeding and eating disorders treatment. A step-by-step path to equity, which includes stakeholders, implementation science, considering the role of culture, and creating new priorities in recruitment/retention strategies, and acting towards reducing barriers and enhancing facilitators to treatment. This figure was created with Biorender (biorender.com)

Additionally, action is needed to identify implementation strategies that may reduce current barriers to accessing FEDs treatment and facilitators that can enhance engagement and retention. For example, with the proliferation of digital health treatment models in the marketplace, researchers have been able to observe increasing opportunities for people to access treatment. Further, with most treatments for FEDs occurring in specialty treatment centers, we see recent evidence that offering treatments in primary care may also have potential [6], particularly for communities with a different seek-help pattern and FEDs/mental health stigma [2].

Clarification of the tools used for the assessment and diagnosis of FEDs will be imperative. Indeed, because individuals from marginalized communities have reported not recognizing that their eating behaviors or disordered behaviors are problematic [6], the field must improve on adapting language and providing

information on disordered eating behaviors and potentially alter how FEDs are discussed with different populations. We must advance our knowledge of the factors contributing to the development of disordered eating behaviors, outside of the traditional emphasis on achieving the thin-ideal. We have a growing body of evidence that highlights the role poverty, trauma, discrimination, and food insecurity have in perpetuating and maintaining disordered eating behaviors [13]. Though our first-stage knowledge of FEDs may serve as a temporary guidepost, we now must make room to incorporate what we learn as the needs of underserved populations manifest.

We also recommend including equity considerations when deciding which interventions to prioritize [9]. In fact, closing access and treatment gaps may require emphasis on developing interventions that work better for those who have been underserved rather than for the majority [14]. Currently, the

available treatments are heavily influenced by both presentation and the developed assessments. However, because treatments based on presentation and assessments have been largely focused on the experiences of cisgender White women, they inevitably reflect the experiences of that population. Currently, the literature on cultural adaptations of evidence-based treatments and clinical trials focusing on diverse populations is limited. Although the use of current evidence-based treatments for binge eating may be feasible and acceptable, different strategies for recruitment/engagement and retention into treatment may be needed to increase cultural sensitivity [7].

Finally, and potentially most importantly, to achieve equity, we must decrease the barriers on receiving adequate training to treat and conduct research on FEDs. Currently, nearly all the advanced training in FEDs is conducted in clinical or counseling psychology PhD programs, a field where nearly 81% of the workforce identify as White (<https://www.apa.org/workforce/data-tools/demographics>). Thus, a first step may be expanding the training programs where entrance into the field is offered. Certainly, social workers, dietitians, nurses, psychologists, and counselors are commonly involved in FED treatment teams. However, numerous barriers exist to making sure these practitioners have the training needed to feel competent providing treatment. Collaborating with other helping professions, as well as amplifying the opportunities for training provided by professional organizations may create an opportunity to expand those with the expertise of treating FEDs and may help raise up a new generation of researchers with diverse identities and backgrounds.

Conclusion

The observable presence of health disparities in the FEDs field has created an opportunity for the pursuit of equity to tackle the disparities in treatment utilization among

underserved populations. Moving forward, it will be critical for clinical treatment organizations and providers to examine the barriers to equitable FED treatment access, and the social determinants of health that may influence treatment outcomes. It will also be helpful to examine the use of effective evidence-based FEDs treatments with diverse populations. Thoughtful reflection will also be needed to determine the cultural relevance of current/detection and screening processes for FEDs in our treatment centers. Furthermore, examining opportunities to partner with community stakeholders engaged in FEDs treatment in one's community, and to engage in a process of cocreation of new solutions to build an inclusive treatment model will help to create a future anew.

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Declaration of interests

The authors declare no competing interests.

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