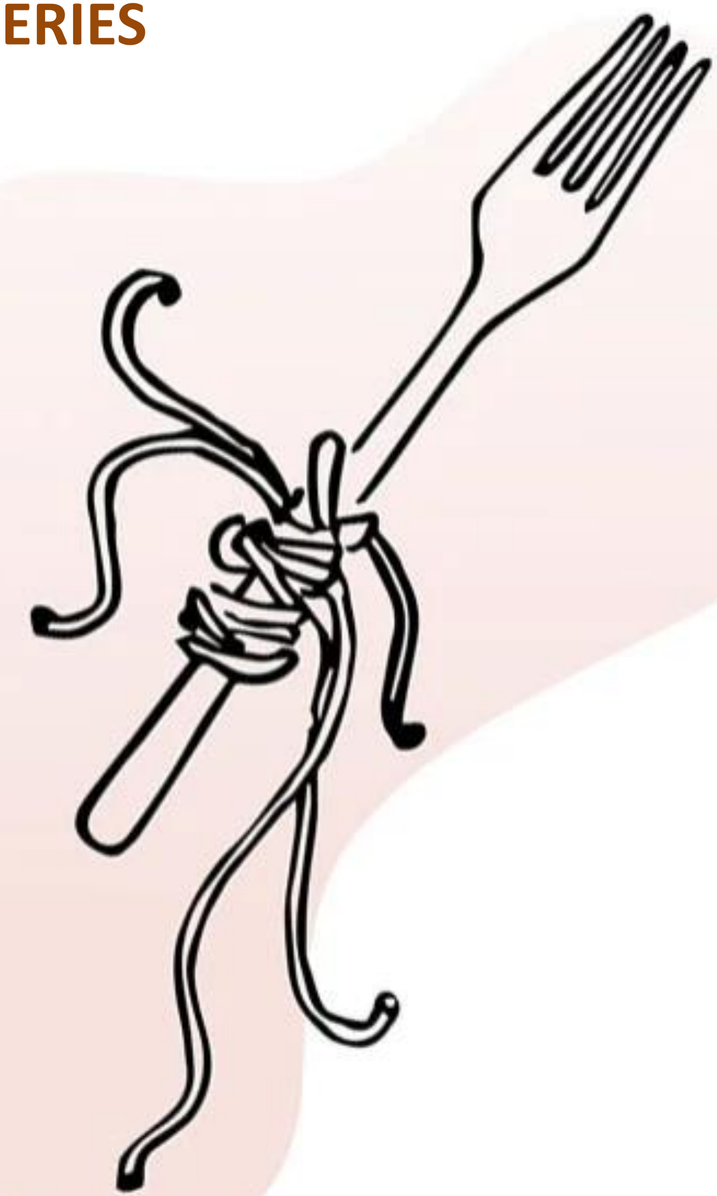
UNC SCHOOL OF SOCIAL WORK CLINICAL LECTURE SERIES

Eating Disorder Risk and Strategies During the COVID-19 Pandemic



Rachel W. Goode, PhD, MPH, LCSW

Assistant Professor, UNC-CH School of Social Work and Department of Psychiatry

PREVALENCE OF EATING DISORDERS

It's estimated that **30** million people in the U.S. will suffer from some type of disordered eating

Anorexia is the **3rd** most common chronic illness among adolescents, after asthma and obesity.

Hudson et al., (2007)
Eating Disorders Coalition (2021)

Let's Talk About Eating Disorders

The way we talk about eating disorders matters. Here are some facts you can use to help shape the conversation around eating disorders.

"Eating disorders are medical illnesses."

Genetic and environmental factors can influence eating disorders. An eating disorder is not a trend or a choice.

"Eating disorders are serious and can be fatal."

Eating disorders often involve serious medical complications that can cause permanent damage or death. People with eating disorders also have an increased risk of dying by suicide.

"Eating disorders can affect anyone."

Eating disorders do not discriminate. They affect people of all ages, races and ethnicities, and genders.

"You can't tell if someone has an eating disorder by looking at them."

People with eating disorders can be underweight, normal weight, or overweight.

"Family members can be a patient's best ally in treatment."

Eating disorders are caused by a combination of genetic, biological, behavioral, psychological, and social factors. Family members do not cause eating disorders and can be great sources of support.

"It is possible to recover from an eating disorder."

Complete recovery is possible with treatment and time.

NIH National Institute of Mental Health

www.nimh.nih.gov/eatingdisorders

NIMH Identifier No. OM 20-4317

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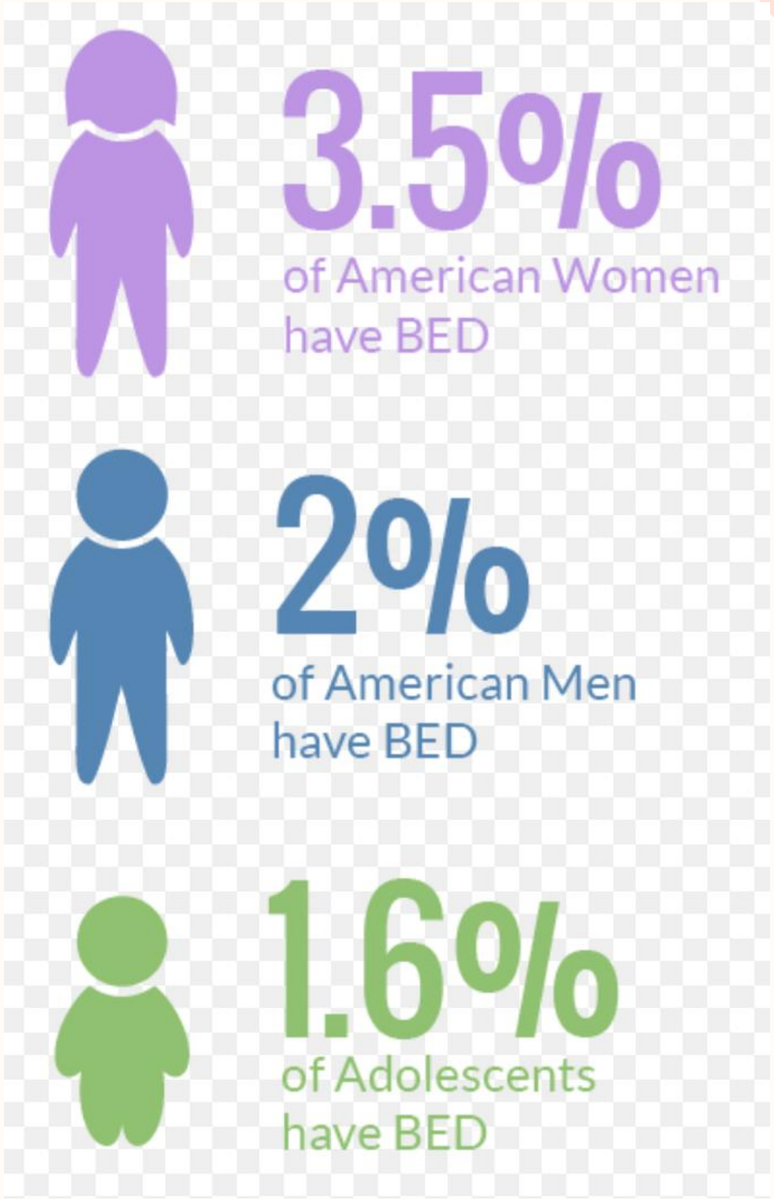
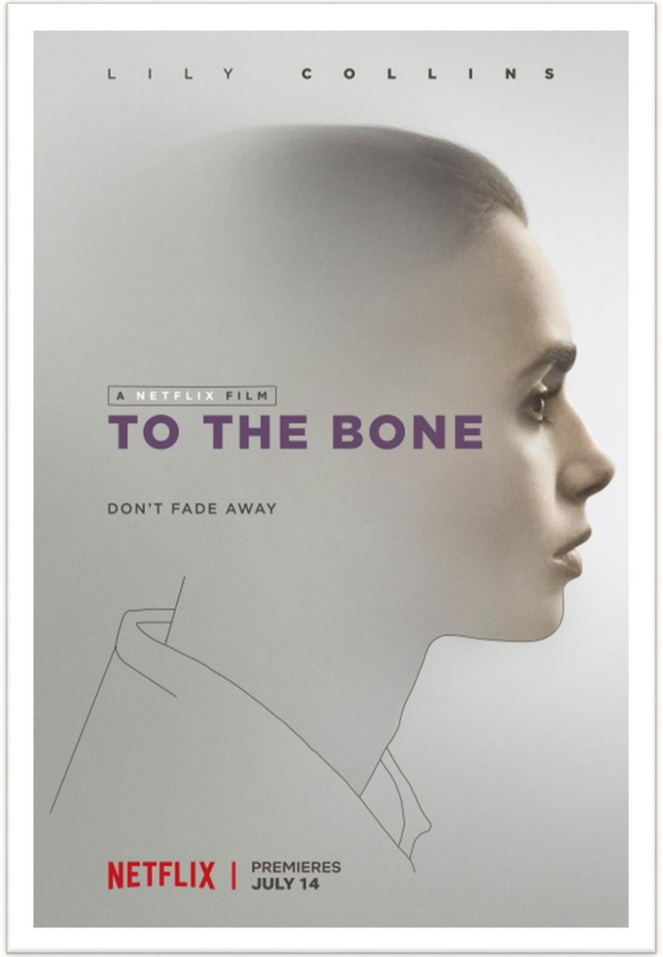
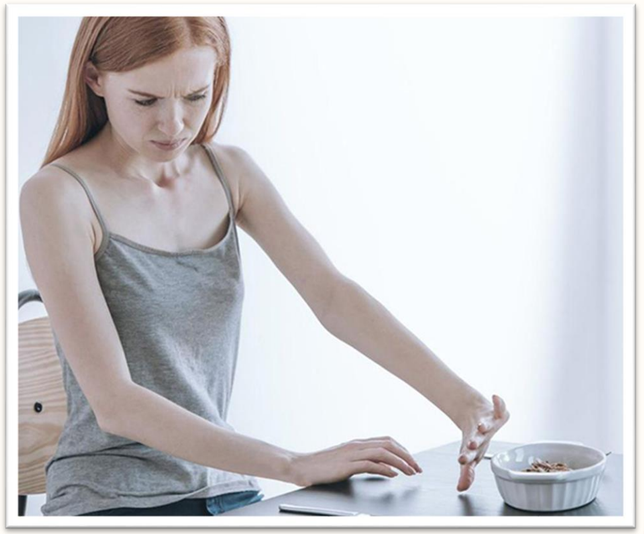
Binge Eating Disorder (BED)
is the most common eating disorder in the United States.
2.8M
An estimated 2.8 million people have BED.
2013
BED was officially recognized as a formal diagnosis.

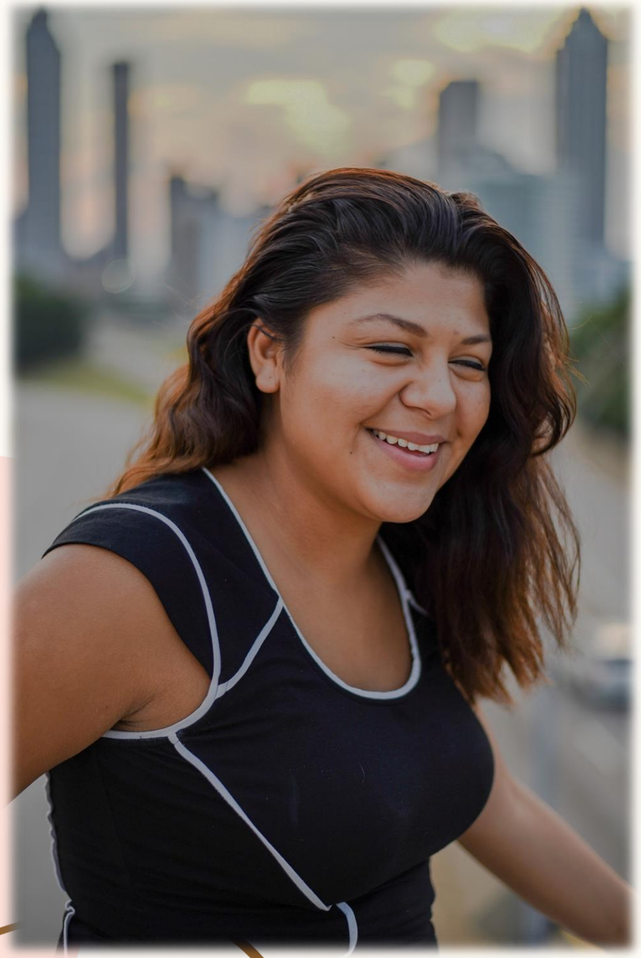

3.5%
of American Women have BED
2%
of American Men have BED
1.6%
of Adolescents have BED

Who struggles with eating disorders?





Face of an Eating Disorder: Reality



Eating disorders are Black Women's
Issues too: https://www.youtube.com/watch?v=YVqCZCf7Xnc

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EATING DISORDERS:
Beyond the Stereotypes

- **Binge eating disorder most common ED across racial and ethnic groups** (Udo & Grilo, 2018).

- **Rates of binge eating may be similar and/or higher in racial and ethnic minorities as compared to Whites (**Marques et al., 2001; Lydecker et al., 2016; Goode et al., 2020).

- **Those experiencing the highest levels of food insecurity, endorse significantly higher levels of binge eating and eating disorder pathology** (Becker et al., 2017).

(Taylor et al., 2013)

EATING DISORDERS:
Beyond the "Thin Ideal"/Contributing Factor

- **Depressive symptoms**
- **Stress**
- **Trauma**
- **Perceived Discrimination**
- **Poverty**

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CNN health

● Follow CNN's live coverage →

Tracking Covid-19 cases in the US

Since January 2020, the novel coronavirus has spread to each state and nearly every territory

By Sergio Hernandez, Byron Manley, Sean O'Key and Henrik Pettersson, CNN

Last updated: February 18, 2021 at 3:45 p.m. ET

Covid-19 has killed at least 492,302 people and infected about 27.9 million in the United States since last January, according to data by Johns Hopkins University.

Eating Disorders and COVID-19

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How has our eating been impacted by the pandemic?

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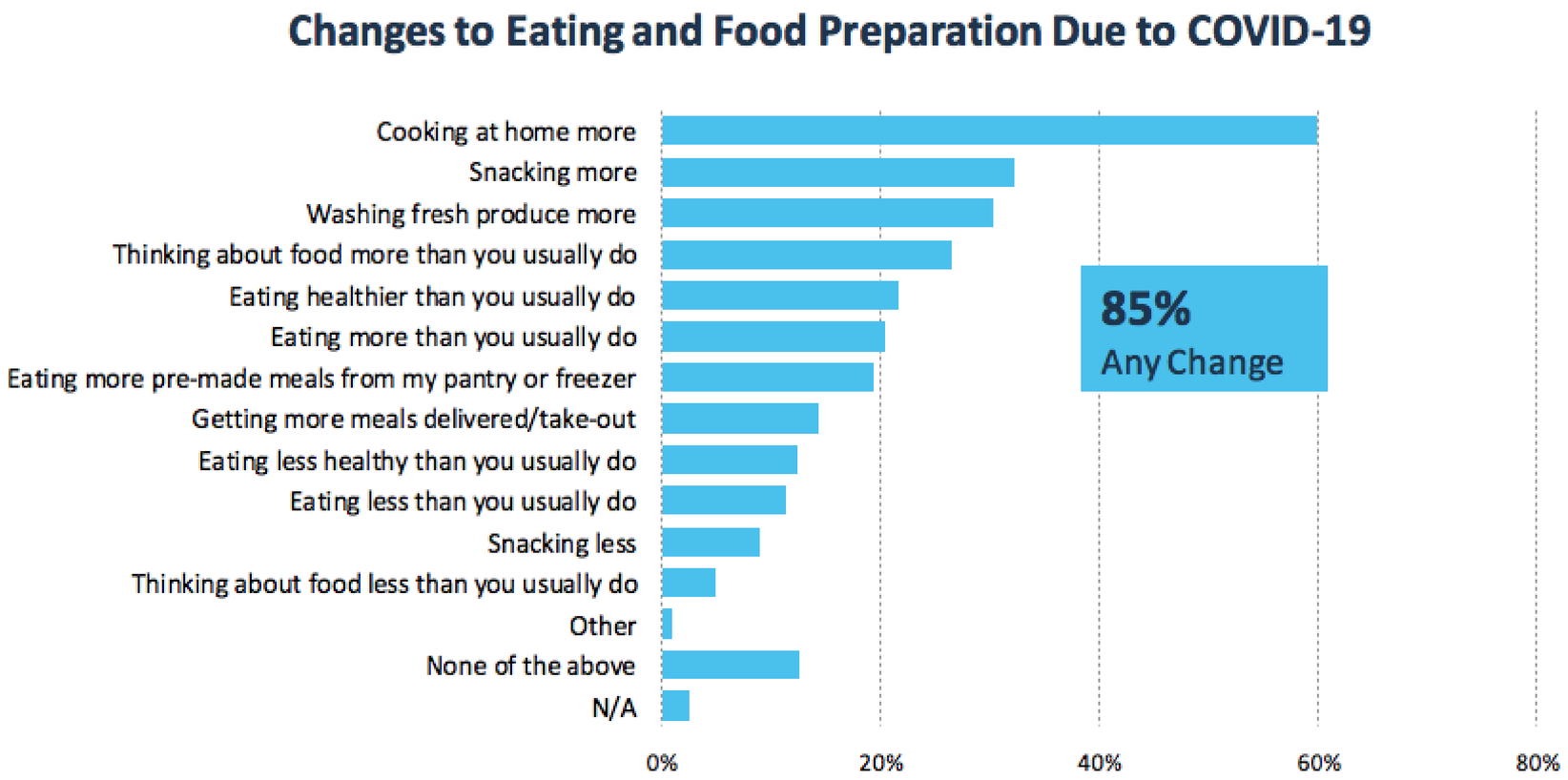
More than 8 in 10 Americans have altered their food habits as a result of the COVID-19 pandemic

Women, those under age 35, and parents are among some of the most likely to have made changes



41% of consumers under 35 say they are snacking more than normal (vs. 26% who are age 50+). Younger consumers are also more likely to have changed their behavior in many of these ways, both in terms of healthy and less healthy choices.

41% of parents with children under 18 are snacking more (vs. 29% without children)

Women are more likely than men to report that they are thinking about food more than usual (31% vs. 22%) and eating more than usual (24% vs. 17%)

Source: *https://foodinsight.org/wp-content/uploads/2020/06/IFIC-Food-and-Health-Survey-2020.pdf*

COMMUNITY ENGAGEMENT | ADVOCACY | HEALTH CARE

54 million people in America face food insecurity during the pandemic. It could have dire consequences for their health

Bridget Balch, Staff Writer

October 15, 2020

Physicians, researchers, and food policy experts highlight the need for accessible, healthy food to combat poor health in vulnerable populations.

Food Insecurity

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Risk Factors for Individuals with EDs during COVID-19

- Food Access
- Media and media messaging
- Exercise limitations
- Restricted healthcare access
- Anxiety
- Social isolation

(Cooper et al., 2020)

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Impact of COVID-19 on Eating Disorder Behavior

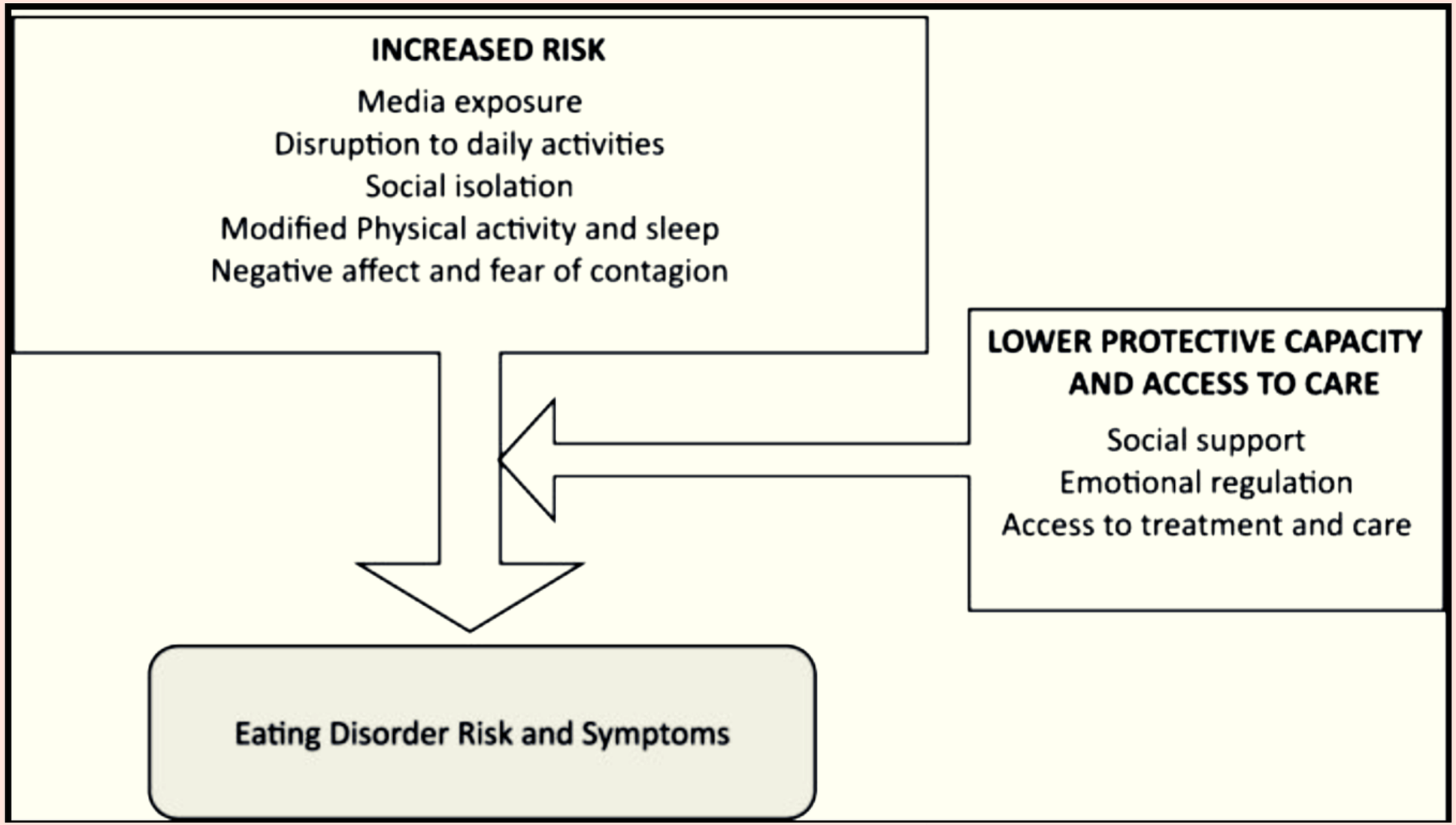
TABLE 4 Impact of COVID-19 on eating disorder behaviors (United States: *N* = 511, Netherlands: *N* = 510)

Items	Country	Not at all (%)	Once or twice (%)	Frequently (%)	Daily or more (%)
In the past 2 weeks, I have binged on food that I (or my family or roommate) have stockpiled	US	51	26	17	6
	NL	71	15	9	5
In the past 2 weeks, I have restricted my intake more because of COVID-19-related factors	US	23	28	29	19
	NL	36	24	25	14
In the past 2 weeks, I have engaged in more compensatory behaviors (e.g., self-induced vomiting, excessive exercise, misuse of laxatives and/or water pills) because of COVID-19-related factors	US	43	22	20	15
	NL	38	24	23	15
In the past 2 weeks, I have felt anxious about not being able to exercise	US	18	25	29	28
	NL	—	—	—	—

Note: NL participants were not asked the question about exercise. Percentages on available data are given. US missing data on individual items ranged from 1% (*N* = 5) to 1.2% (*N* = 6) and NL missing data on individual items was 3.5% (*N* = 18).

Abbreviations: NL, Netherlands; US, United States.

(Termorshuizen et al., 2020)



(Rodgers, R. F., et al., 2020)

"Listen to Her" Study: Preliminary Results

- **Who**: Black women reporting binge eating episodes in the COVID-19 pandemic (N= 20)
- **Method**: Qualitative, Semi-structured Interviews
- **When**: March 2020 – January 2021
- **Funder**: University Research Council, UNC-Chapel Hill

Living F.R.E.E. Lab

Research Focused on Reducing Excessive Eating

www.livingfreelab.org

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In her own words...

*"**I find myself eating ice cream and, cookies three, two or times a day** and bedtime, which are **things that I never did before COVID**, and before COVID I could eat a bite of any dessert and be completely satisfied. Since COVID, I have wanted to eat the whole dessert. That's different. **That's very different**. And I have been this way for years when it came to dessert, one bite enough, satisfied, done. **Since COVID, I'm not satisfied with anything and God it, feels like I'm never done."***

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In her own words...

"I'm going to be very clear that that would not be my typical, ***I think COVID changed things for me****...most days of the week is when I'm just* ***not controlling my eating and I'm having binge episodes*** *and they're mostly at night. I would say it's mostly difficult to manage at night and I work a lot. I work really long hours sometimes. And so, at night I'm up late, I'm working, I'm on my computer.* ***And so it's just like, okay, I'm bored...It's just, it's like, it's late, I'm working. I'm tired. Let me go eat something****."*

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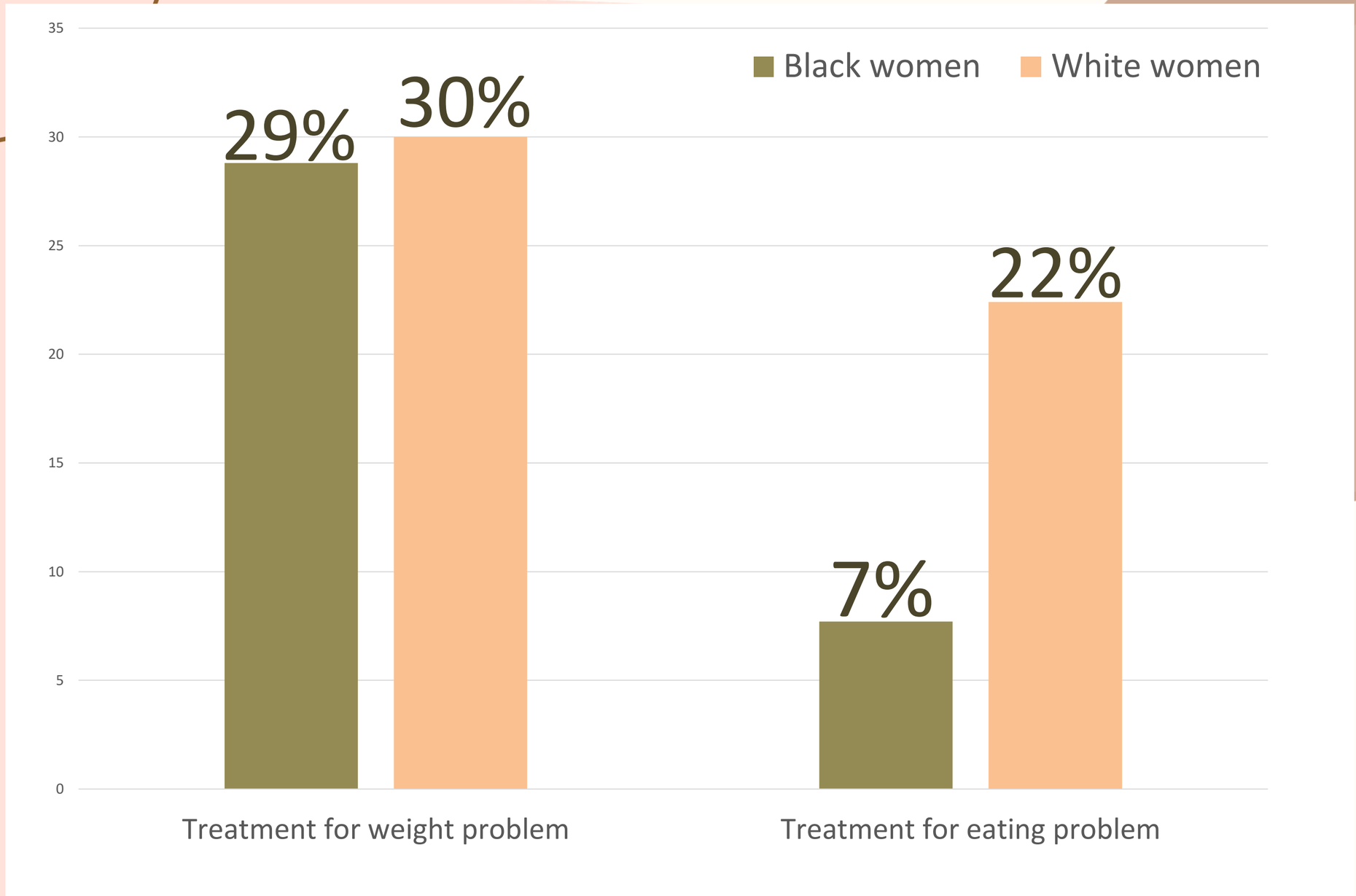
COVID-19 has only exacerbated disparities in treatment options.



(Pike et al., 2001)

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Table 3. Endorsement of reasons for not seeking treatment by women with eating disorders

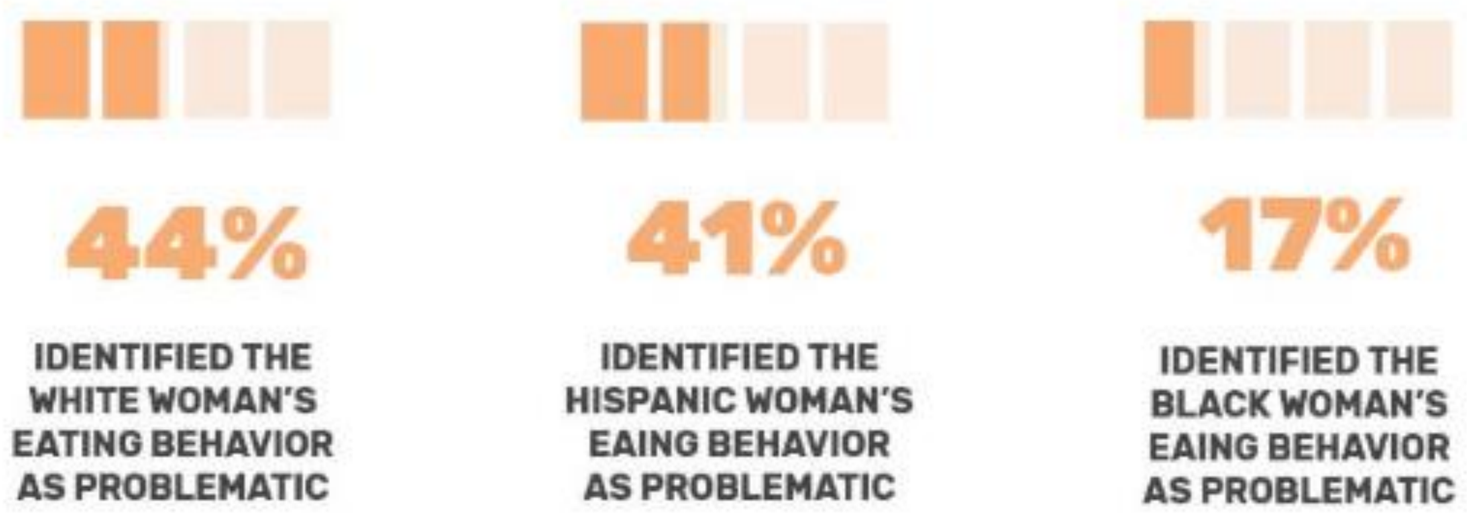
	Total (n = 29)[a]
Financial difficulties	17 (58.6%)
Lack of insurance	14 (48.3%)
Others can't help	11 (37.9%)
Fear of being labeled	10 (34.5%)
Not knowing about resources	10 (34.5%)
Feelings of shame	9 (31.0%)
Fear of discrimination	6 (20.7%)
Turning instead to other sources	6 (20.7%)
Don't think I have a problem	4 (13.8%)
Counselors not of same ethnic background	3 (10.3%)
Lack of transportation	3 (10.3%)

Note: Individuals may have endorsed more than one barrier.

[a]Responses of three individuals who expressed that initial treatment contact made them unwilling to seek further treatment are included in this sample.

(Cachelin et al., 2000)

When presented with identical case studies demonstrating disordered eating symptoms in white, Hispanic and Black women, clinicians were asked to identify if the woman's eating behavior was problematic:[15]



(Gordon et al., 2006)

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Treatment considerations during COVID-19

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An Introduction to the Cultural Formulation Interview

Neil Krishan Aggarwal, M.D., M.B.A., and Roberto Lewis-Fernández, M.D., M.T.S.

This article explains the origins, development, and applications of the DSM-5 Cultural Formulation Interview (CFI). This work first discusses the relevance of cultural factors to all aspects of mental health care, demonstrating the need for person-centered cultural formulations in diagnostic and treatment planning. The DSM-IV Outline for Cultural Formulation is then reviewed as a framework for conducting cultural formulations. Key revisions from *DSM-IV* to *DSM-5* are covered, including a consensus definition of culture relevant to mental health, guidelines for conducting cultural formulations in practice, and explanations of various CFI questionnaires for providers. Finally, this article provides a detailed examination of the core, 16-item CFI, the content of which serves as the foundation for all questionnaires. The CFI can be used to promote culturally competent practice that clarifies the meanings and expectations of health, illness, and treatment from the patient's perspective.

Focus 2015; 13:426–431; doi: 10.1176/appi.focus.20150016

Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress, the patterning of symptoms, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses. Culture also shapes patients' perceptions of care, including what types of treatment are acceptable and for how long. Even when patients and clinicians share similar ethnic or linguistic backgrounds, culture affects care through other influences on identity, such as those attributable to gender, age, class, race, occupation, sexual orientation, and religion/spirituality. Because cultural contexts and expectations frame the clinical encounter for every patient, and not just those from underserved minority groups, cultural formulation is an essential component of any comprehensive psychiatric assessment.

Acknowledging that illnesses occur in cultural and social contexts, *DSM-5* includes two questionnaires to aid clinicians with cultural formulation. The first questionnaire, known as the core Cultural Formulation Interview (CFI), contains instructions for clinicians in a left column and 16 questions with probes for direct patient interviewing in a right column, similar in format to other standardized questionnaires such as the Structured Clinical Interview for DSM-IV. In addition, there is an informant Cultural Formulation Interview (I-CFI) for clinicians to use with close associates of patients, such as family, friends, caregivers, and others who can provide collateral information. Finally, *DSM-5* includes 12 supplementary modules to the core CFI, which provide additional questions to investigate a topic in greater depth or include topics of additional concern (e.g., phase in the life cycle for certain populations, such as children and adolescents or older adults).

This set of interviews is known collectively as the CFIs, and they greatly expand the clinician's tool kit so that attention to cultural issues remains integral throughout the process of diagnostic and treatment planning. APA has made all of these interviews available online for free on its Web site (www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures) in recognition of the growing interest in clinician cultural formulation. This article reviews the development of the core CFI and discusses its contents in detail so that clinicians can develop a working understanding of the theoretical foundations common to all of the interviews.

DEVELOPMENT OF THE CFI

Outline for Cultural Formulation

The core CFI, I-CFI, and all 12 supplementary modules were developed by the *DSM-5* Cross-Cultural Issues Subgroup (DCCIS) based on reviews of the scientific literature since the publication of the Outline for Cultural Formulation (OCF) in 1994. The development process is discussed elsewhere in greater depth (1) but is summarized here for background. The OCF was an early attempt at standardizing cultural formulation that first appeared in *DSM-IV*. The OCF was developed as a conceptual framework—a summary of the topics that could be included in a cultural formulation during a mental health evaluation to improve diagnostic accuracy and patient engagement in treatment planning.

> Cultural factors are relevant to all aspects of mental health care

> **16-item Cultural Formulation Interview** can be used to promote culturally competent practice and clarify meanings and expectations of treatment from client perspective.

> Four domains to explore *cultural definitions of problem, perceptions of cause, and factors affecting help-seeking*

(Aggarwal & Lewis-Fernandez, 2016)

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The Non-Colorblind Assessment

- **Asking the "Hard" Questions (Fuller & Small, 2020, p. 24)**

Potential Assessment Questions
What is most important to you about your culture/ethnicity?
What influence has your race/ethnicity, religion, spirituality, gender, class, hair played in shaping your body image?
What has it been like for you growing up in a culture of racism?
What messages about food have they received?
What messages do they tell themselves about food and eating patterns?
What factors related to oppression does your client discuss?
Do they identify with being "all" to others (i.e., Strong Black Woman Syndrome)? (Giscombe et al., 2010)
What are triggers to eat or not eat?

What Therapists of Color Should do:

- Remember: Misunderstanding and bias also exists *between* people of color
- Separate your worldview and experiences with oppression from that of your client
- Take time to understand the client's experience with racism, sexism, and gender identity concerns
- Evaluate your racial identity status and consider how this may influence your work with clients of color
- Aware of your bias and implicit bias, seeking continual growth

(Sue & Sue, 2015)

What White Therapists Should do:

- Examine your racial identity and how it has impacted you
- Take time to understand the client's experience with racism, sexism, and gender identity concerns
- Begin or continue a journey to uncover your areas of bias and implicit bias, seeking continual growth
- Invite clients to share on the impact of racism in their lives
- Respect and join in the lived experiences of marginalized populations

Implications for Interventions

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Janse van Rensburg *Journal of Eating Disorders* (2020) 8:26
https://doi.org/10.1186/s40337-020-00306-3

Journal of Eating Disorders

LETTER TO THE EDITOR Open Access

COVID19, the pandemic which may exemplify a need for harm-reduction approaches to eating disorders: a reflection from a person living with an eating disorder

Margaret Janse van Rensburg

Abstract

This reflective piece, written by a woman with an eating disorder aims to identify the impact of COVID-19 on persons living with eating disorders and provide a social justice approach as a resolution. The author identifies that eating disorder behaviors may be the only coping tool available for many persons with eating disorders during this time of uncertainty. While she acknowledges the risks associated with eating disorder behaviors, she identifies that this time of uncertainty may be a time to embrace harm-reduction in approaching the health and wellness of persons with eating disorders.

Keywords: Reflection, Harm reduction, Strengths-based approach

Main text

Touyz, Lacey, & Hay [8] published the editorial "Eating disorders in the time of COVID-19", which outlines the unique impact of COVID-19 for persons with eating disorders (EDs). However, they provide little suggestions for readers as to how this impact can be managed. This letter seeks to promote a harm-reductionist approach to EDs during this uncertain time.

I identify as a person who lives with an eating disorder (ED). First diagnosed at fifteen, I spent my adolescence and young adulthood in therapeutic settings seeking normalcy. I completed a plethora of programs, therapies, and experimental treatments for my ED. My symptoms have decreased markedly, but I still question 'recovery'. I have just completed my Master of Social Work which has an ethical commitment to social justice. I believe a social justice approach to EDs would prioritize harm-reduction.

Touyz, Lacey, & Hay [8]'s report of the impacts of COVID-19 on persons with EDs are accurate. For me, grocery shelves becoming empty of my staples caused me great anxiety. "How am I going to adapt my eating schedule?" I asked myself. Social isolation has meant that there was little available for me in terms of 'crowding out' the ED with other meaningful activities. While I claim no expertise in this area, I can also imagine that there are a plethora of reasons why persons with EDs may be at higher risk of contracting COVID-19, including persons with EDs having more hand-to-mouth behaviors, having an inability to isolate, and having more contact with health care settings that have COVID-19 outbreaks. I can also extrapolate that COVID-19 has been a real nightmare for care providers, who may be unable to provide, or be forced to adapt, recovery-centered support.

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Carleton University, Ottawa, Canada

> A harm reduction approach to ED management in COVID-19?

> Task of recovery may be unattainable for some, and other alternatives may need to be explored

> Creating goals that increase safety of ED behavior, rather than reduction or abstinence

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Treatment considerations:
Role of Web-based Information

(Weissman et al., 2020)

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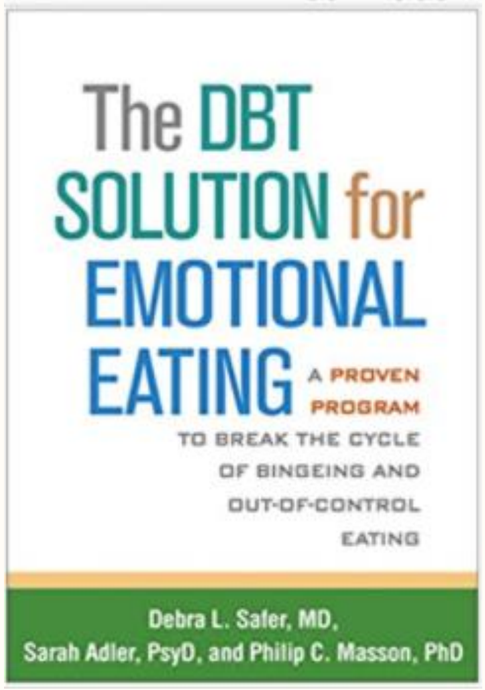
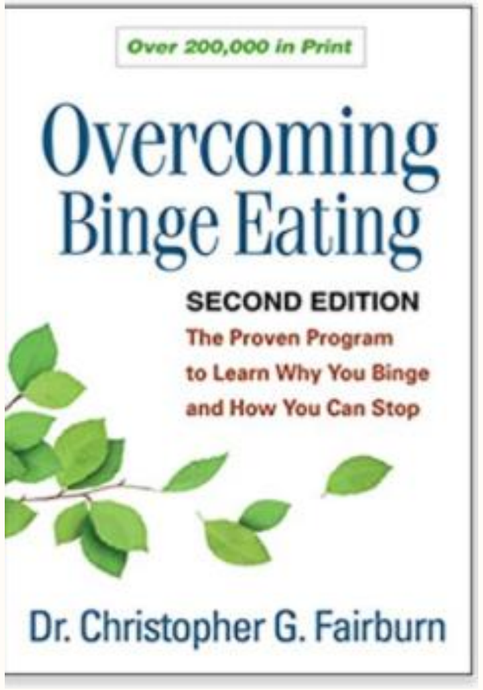
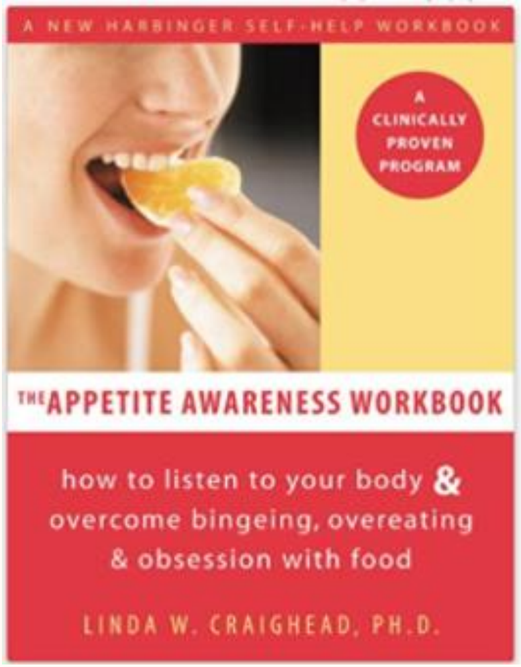
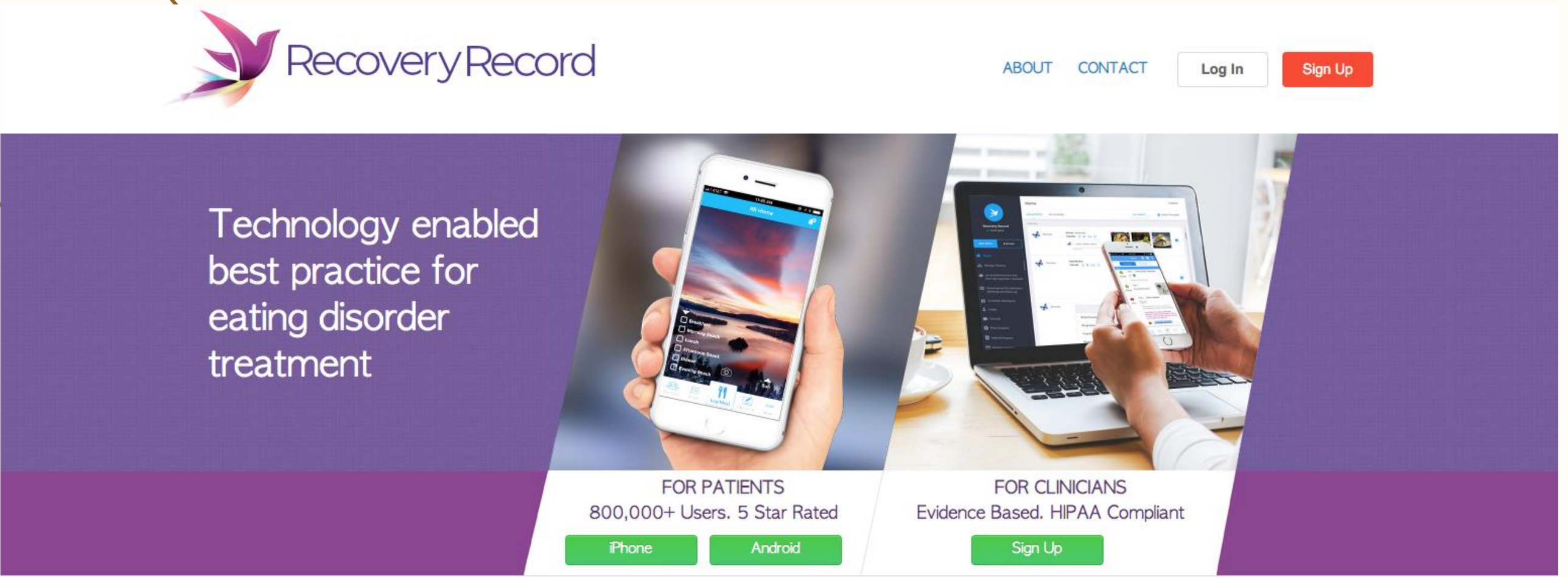
Treatment considerations:

Improving access to self-care resources









Digital Health Tools for Self-Monitoring

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Pertinent Interventions (Cooper et al., 2020)	
Accessible Treatment Options	• Telehealth • Guided self-help • Email and text messages • Digital tools for self-monitoring • Online support groups
Targeting specific eating and food-related challenges	• Reassessment of meal plans and flexible meal planning • Maintaining daily structures and routines • Focus on internal awareness of satiety and hunger • Use self-compassion toward current struggles • Encourage focus on body functionality • Challenge unhealthy food-related cognitive distortions • Practice exposures to challenging foods

(Cooper et al., 2020)

Thank you

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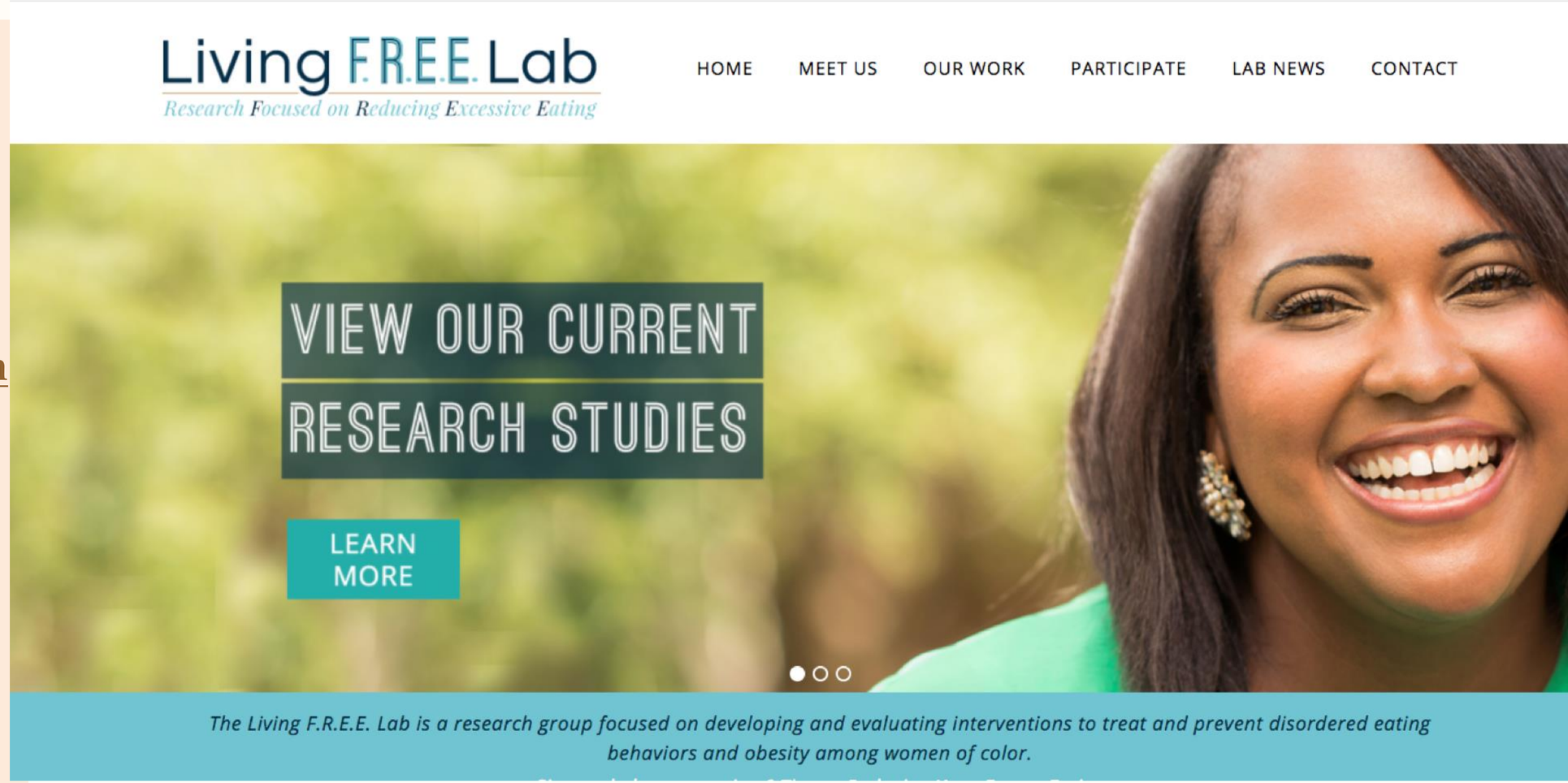

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Discussion and Questions

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