“No more Secrets”: Shedding Light on Eating Disorders in the African American Community Webinar Transcript

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la-shell_johnson@med.unc.edu: Good afternoon, everyone. I would like to welcome you to today's presentation brought to you on behalf of the National Center of Excellence for Eating Disorders and the African American Behavioral Health Center of Excellence.

la-shell_johnson@med.unc.edu: I wanted to start off with a few things to note, participants will be muted upon entry and videos turned off. For technical assistance, we ask that you use the chat box.

la-shell_johnson@med.unc.edu: You will also receive an email in approximately three months requesting feedback and impact on today's presentation.

la-shell_johnson@med.unc.edu: We also are going to provide you with additional training materials that we offer via the NCEED Training Center. To view those we've asked for you to go www.nceedus.org/training, you will also receive a copy of today's slides tomorrow via email. For your certifications, you will receive information at the end of today's presentation for contact, regarding which certificate, you would like to receive for your continued education credits. I will now go ahead and introduce today's presenter, Dr. Rachel Goode, who will be presenting on the title, “No more Secrets”: Shedding light on Eating Disorders in the African American Community.

la-shell_johnson@med.unc.edu: Dr. Rachel Goode is an Assistant Professor at the School of Social Work at the University of North Carolina at Chapel Hill and a key content expert within the National Center of Excellence for Eating Disorders.

la-shell_johnson@med.unc.edu: The focus of her research is to develop, implement, and evaluate interventions to prevent and treat disordered eating and obesity among African American women. Her ongoing projects include, a NIH career development award to develop a culturally relevant digital treatment for the treatment of binge eating and Black Americans, and an innovative clinical translational science award from the American Diabetes Association to improve treatment for binge eating among African Americans with Type 2 diabetes.

la-shell_johnson@med.unc.edu: I will now go ahead and turn things over to Dr. Rachel Goode.

Rachel Goode: Thank you for that introduction La-Shell. I am excited to be here with you all today to talk about eating disorders in Black Americans in our Community. You know there's so much that we still don't know, and so I'm looking forward to just us beginning a conversation right, having a dialogue with one another as we really begin to highlight something that has not been talked about as much among Black Americans. And, hopefully, that we will take steps to change that.

Rachel Goode: So, I just want to honor the sponsors for our presentation today. To honor NCEED for their mission to advance education and training of healthcare providers and to help increase awareness of eating disorders and eating disorder treatment.

Rachel Goode: And then, I also want to honor the African American Behavioral Health Center of Excellence. I'm just grateful for the work that you're doing to just improve our access to behavioral health treatment and educating us on the various programs and systems that might be helpful.

Rachel Goode: So, today, the purpose of our talk today is one we're going to do a couple things. We're going to examine and describe the prevalence of DSM-V eating disorders and some of our challenges in access and treatment retention for Black Americans. We're going to discuss relevant factors and the development of eating disorders and Black Americans.

Rachel Goode: And then we are going to discuss strategies for some culturally relevant assessment tools and the treatment of disordered eating behaviors.

Rachel Goode: I think one of the first things that's important to discuss, and I often do this in many my presentations is, we have to talk about there's so much we don't know about eating disorders.

Rachel Goode: And so, when I think about what's relevant for Black Americans. I think the first thing that jumps out to me is that eating disorders can affect anyone.

Rachel Goode: Okay, and so I think we have been harmed by misconceptions outside of our community within our communities that only certain people get eating disorders, but that is not true. They affect people of all ages, races, ethnicities, and genders. Also you cannot tell someone has an eating disorder just by looking at them.

Rachel Goode: This has also negatively impacted many in the Black American community because people have assumed that you know because maybe our body types are different, or certain symptoms look different.

Rachel Goode: We do not have eating disorders and again, that is not true, and hopefully by the end of our presentation you all will have some more information to help continue to improve our dialogue and our knowledge on this topic.

Rachel Goode: So this is the image of who we have believed, right eating disorders have typically been assumed to be a White adolescent cisgender female concern. And so, but the truth is, is that we all, all of us have the potential to have an eating disorder.

Rachel Goode: Especially living in a country where weight has been at the forefront of dialogue, for many, many years. It is very easy to begin a disordered relationship with your body and that translate into disordered eating.

Rachel Goode: And so, as we recognize that all of us can have eating disorders. It's important to acknowledge, some of the stereotypes right, and to go beyond that.

Rachel Goode: So, if we really look at the evidence, Binge eating disorder is the most common eating disorder and Black Americans. In fact rates of binge eating may be similar or even higher in Black Americans as compared to Whites, and among those who are experiencing food insecurity. And they endorse in the highest levels, we see significantly higher levels of binge eating and eating disorder pathology.

Rachel Goode: We also recognize that body image dissatisfaction is something that plagues Black Americans and it's, particularly among women being dissatisfied with one's body image is a strong predictor of binge eating in Black women. So historically, we have thought again Black women don't know, they don't struggle with body image in the same way, you know.

Rachel Goode: With like curvier figures, we prefer you know we don't have as much. I don't know, there's not as much stigma about carrying excess weight, but that does not mean that there are not people who feel like they want their body size to be different. And what we see is that relationship between the experience of body image dissatisfaction and eating disorders. We see the highest rates of body dissatisfaction when individuals are preferring a body type that might be more endorsed by mainstream culture.

Rachel Goode: And they're buying into some of those norms, we simply see some of the most, the strongest relationship between body dissatisfaction and eating disorders. And so we're learning that we need to continue to investigate this relationship in Black Americans, because this is still here. Body image is still a concern and we are going to have to learn more about how it's related, and how to treat it, especially when it comes to the treatment of eating disorders.

Rachel Goode: So when we think about it, these are the three most common eating disorders, not every eating disorder is present here, but anorexia nervosa, bulimia nervosa, and binge-eating disorder are the three most common eating disorders here, and so what we see is that among Black Americans, binge-eating disorder and bulimia nervosa are some of the most common. So this is the lifetime prevalence of these two eating disorders and our population. And so the one thing you might think of is oh 1.4% or 1.6% like that seems very small, but I think what's most important to realize is that eating disorders are not typically treated, people aren't usually going into get help. It's particularly when we might not even realize that an eating disorder can be present. So, these numbers likely underestimate greatly the prevalence of some of this disordered eating that might be present in our communities.

Rachel Goode: We have to consider just some of the factors that might affect the development of disordered eating and how it might look different in Black Americans. So, one thing I think that's been protective, but not completely protective, is that there are just some alternative views of weight and shape.

Rachel Goode: And so, I read this text and I loved how the author said this, there's just an increased flexibility.

Rachel Goode: When it comes to body shape, there's still ideals definitely, but there's just an increased flexibility right and so there's less emphasis on achieving the thin ideal.

Rachel Goode: In addition, there is a lack of there might be just a lack of eating disorder awareness due to those stereotypes, where we might have disbelieved that.

Rachel Goode: Black Americans don't struggle with eating disorders, and so because of that we, I think, culturally there isn't a lot of information on what an eating disorder is, how might I know I have an eating disorder.

Rachel Goode: And these are things that might make it challenging for many to get the help that they need.

Rachel Goode: We also have to consider what does food mean within a culture right? We think about historically Black Americans have had to be especially black women had to be mosaics.

Rachel Goode: Creating architects of beauty, with little to anything, often with scraps that were left over. We think about slavery. After we were freed, we were sharecroppers, you know, thinking we did not have much, and so we had to make it be beautiful. And so because of that food has been something that culturally you're very proud of, and it means a lot. It sends love to each other when we are cooking and sharing food with one another. And so, in order to understand how disordered eating like develop, we have to understand that context and recognize that as food can be a form of coping, and it can be something that is used. And, we'll continue to see in this presentation that can be used to really kind of be a shelter from the outside world, and I think in Black American culture, it has really been something that has been very comforting and a very protective part of our culture.

Rachel Goode: So I wanted to share this clip of a young woman talking about her experience managing an eating disorder, and I think it'll set the tone for our conversation today.

Rachel Goode: As a Black woman with anorexia it's a different experience, because I not only have to kind of deal with the all the eating disorder symptoms that are already there but, I have to deal with how it relates to my racial identity in knowing that my body as a Black woman is never going to look like a White woman's, I am not going to be underweight.

Rachel Goode: due to muscle mass and bone density and so having all of the symptoms of someone with anorexia and really struggling, but I'm sometimes not getting treatment because I'm not underweight so I can't be admitted places or have an official diagnosis.

Rachel Goode: Or if I do have the diagnosis, still feeling so much denial about it because I have a voice in my head telling me that I don't have this or that I'm not, I'm not sick enough, I'm not thin enough to be anorexic, but also having the outside world, not really be able to see it either.

Rachel Goode: It feels isolating, it feels isolating knowing that this isn't something that a lot of Black women have shared their stories of having anorexia and being somebody who deals with that.

Rachel Goode: It feels like I'm sort of in between like I don't get to be a Black person, but I don't, I'm not a White person either. I just kind of am stuck in this in this lonely place, and I'm not really sure where to go from there. When I talk about it in treatment most of the doctors are White, and so they don't really understand what it's like for me from a cultural perspective.

Rachel Goode: They can be educated about it, but truly getting it, to find somebody who really gets it is hard. So, it just feels, it feels very alone.

Rachel Goode: I would say to treatment providers and clinicians to not assume that because somebody looks a certain way that they have a disorder and not.

Rachel Goode: A lot of the time Black women just, it's assumed that they don't have an eating disorder, anorexia, bulimia, binge-eating disorder, it's not even screened.

Rachel Goode: And so, I would just say that to remember that eating disorders don't have, they don't have a face. They don't have a representative. They can be in anyone, and they don't, they don't discriminate. And so in the world of treatment, we shouldn't either, we should look at it, the diagnosis and the eating disorder for what it is and see that it can affect anybody and treat everyone who has them. Because everyone deserves help, everyone deserves to be seen, no matter the, the body that they're in or the skin color that they have.

Rachel Goode: What I hope you all take from this brave young woman who was speaking is just a reminder right we have so many misconceptions that.

Rachel Goode: We have to kind of push back against, and who is often left suffering are those who are kind of needing the help at the time. So, it's going to be so important as we move forward that we work to uncover the truth about eating disorders and really prepare our practitioners, so that they can effectively practice to help treat and help our people to heal.

Rachel Goode: So I think, as I use that video to begin our discussion on the factors contributing to disordered eating in Black Americans what we've seen in the research literature, you know we think about some of the commonly held beliefs. That the overvaluation of shape or weight is kind of the reason why an eating disorder would develop, and that is one factor definitely that but you see here, there are other things that we've seen in the research that affect disordered eating the development of eating disorders in Black Americans and we're going to take the time to unpack them, bit by bit.

Rachel Goode: So one of the first ones that I think it's important to see is the role of poverty and food insecurity. And you can imagine, if you grew up in a home where access to food was limited and you weren't certain of where you weren't or we're going to get your next meal. So you might have experienced periods of restriction right, because or deprivation. Because you have sensed that you know you weren't able to access food in a place where you want it to access it. Whether you skip meals, whether you might find yourself trying to maybe overindulge in food when it's available, so you know,

because you know, there might be a period when it's not available. So, we see these patterns really showing up among individuals who are experiencing, or either previously have experienced. Maybe grew up in childhood poverty or might currently being experiencing food insecurity.

Rachel Goode: And so, when we see, particularly among individuals who are in households where they are experiencing the various highest levels of food insecurity, meaning there are children in the home who, they are not certain that they're going to have food to feed when we see individuals in those circumstances.

Rachel Goode: We see higher levels of binge eating, higher levels overall of eating disorder pathology, we see higher levels of weight stigma. You know these are things that are present all while people are managing the context of poverty. We see these other things are this disordered eating develops as well.

Rachel Goode: We also acknowledge the role of trauma, and so individuals who have experienced childhood sexual trauma, childhood other traumatic events that might have happened.

Rachel Goode: We see higher rates of disordered eating and so some researchers have theorized that part of the reason for this might be the body's way of coping with the trauma and being able to kind of put it somewhere. And so, a place sometimes when individuals cannot control some of the things that are happening to them, they often are able to control the what, they're eating and be able to put the focus there. And, so we see that disordered eating can be often a result of some of these traumatic experiences.

Rachel Goode: We also cannot talk enough about the experience of racism and discrimination and micro aggressions when it comes to disordered eating. We have to think about often we see this really show itself when individuals are maybe in environments where they might be the only person of color, the only Black person in a work environment that's predominantly White. And, so when it comes to the we think about body type and feeling the pressure of acculturation, sometimes individuals in these spaces have developed disordered eating as a way as they're managing that sense of just not fitting in the environment and the pressure.

Rachel Goode: Sometimes right, the stigma that they're experiencing and one thing that they can do, even though they of course they cannot change their skin color, or they may not even want to.

Rachel Goode: But to have a body type that fits the norm that might be seen in the mains in the dominant culture.

Rachel Goode: In addition, sometimes individuals are managing and we see this with those who have experienced higher rates of discrimination. We see a relationship sometimes between coping tools and the eating behaviors can often just be a tool to cope with some of those experiences. A way to speak things that sometimes we don't have the words to speak, we can use our eating and it's a way for us to communicate some things that might be very painful.

Rachel Goode: We also have some research to think about the role of strong Black woman syndrome. So this is the pressure, sometimes Black woman feel to kind of be all things to all people, to not say that you have had enough, but to kind of literally carry the weight of the world on your shoulders.

Rachel Goode: And so, in the literature, we are noticing that among trauma survivors, particularly those who identify with the strong Black woman syndrome, so I can identify with some of that pressure feeling like you have to just take it and not be able to speak some of the things or deal with some of the things that you are facing. We see higher rates of binge eating, and we are wondering if it could be just the result, often when individuals are engaging and binge and emotional eating they're often not being able to speak verbally some of the things that there are most upset about or feel powerless to change some of those things.

Rachel Goode: And we continue to see that this might also be a factor in the development of binge eating among Black women.

Rachel Goode: So now I'm going to show you some studies, where we're going to just talk about what we know right. There are definitely many deficits in our current literature and we don't know enough, but we have learned some things about how eating disorders show up in Black populations. And so I'm hoping to share some of that with you.

Rachel Goode: So this chart, just to orient you to the chart, this was a study that was done in about 775 treatment seeking adults for binge eating or other eating disorders. And so what this study was looking to see is what are some of the racial differences, and just kind of the onset of disordered eating, the onset of obesity, the onset of dieting, and do we see any differences so over here this chart is showing just okay, so the orange the blue is the onset of obesity okay.

Rachel Goode: And, so we see here that in Black patients, the onset of obesity was a little later than it was for about similar to Hispanic.

Rachel Goode: But a little, but definitely a little later than White patients and then there's yellow is the next step, often in our country when someone has is trying to lose weight they will often begin to diet.

Rachel Goode: So this yellow is the dieting right, and you see all across the races that it's different, and then the Green is then individuals, then developed binge eating.

Rachel Goode: And then, this orange shows that they developed binge-eating disorder, which represents severe binge eating behavior.

Rachel Goode: What we see here is that individuals, Black individuals, their developmental trajectory like they move much more quickly through these phases.

Rachel Goode: Then we see, especially as compared to White participants. And, what we notice is that with Black Americans, when they enter treatment they often present with higher BMI, right they have more weight. But they have the same weight shape and eating concerns, and they have similar or more frequent binge eating episodes.

Rachel Goode: Another study was looking at Black and White patients who are coming in, for another treatment for disordered eating.

Rachel Goode: And so we see here that across the races, we see that Black and White participants have very similar binge eating episodes. For those who aren't familiar there's objective binge eating, so that's consuming on a standard and objectively large amount of food, while experiencing loss of control.

Rachel Goode: And then we have subjective binge eating episodes so maybe the size wasn't as large, but these participants were still saying that they experienced loss of control.

Rachel Goode: And so there's not many differences and between Black and White participants when it comes to some of these compensatory behaviors however, we do see differences when it comes to me for the binge eating episodes we do see differences in compensatory behaviors..

Rachel Goode: So, when individuals have anorexia nervosa they also will have some compensatory behaviors like vomiting, laxative misuse, or diuretic misuse, and so in Black participants, we see much less vomiting, significantly less vomiting but very similar amounts of laxative misuse. So what this means is that when patients are presenting, and they might be describing symptoms of eating disorders, they may be, oh these individual does not have bulimia nervosa because they don't, maybe they don't have the vomiting.

Rachel Goode: But what we see in our research is that they have they just use different things, and so that just further lets us know that we need to know how we can assess disordered eating in this population, because we might be missing individuals who might indeed be struggling with some compensatory behaviors, but they are not vomiting.

Rachel Goode: So also thought it'd be helpful for us to just think about COVID-19 and how that has impacted eating disorders in this population. So what we have seen it just across this was a study done by several authors here in the University of North Carolina at Chapel Hill and then across in the Netherlands and Sweden. And so, they were looking at the impact of COVID-19 or eating disorders. And so, what we see just again across these countries is that people have been struggling right, they have struggled we have seen increased binge eating behavior, increased restriction, increased compensatory behaviors, and then anxiousness, because individuals aren't able to exercise.

Rachel Goode: When we have put it together and looked at a review of just what we've learned, we see that individuals, as COVID-19 was raging right, those who were struggling with eating disorders were managing.

Rachel Goode: One, they didn't have access to some of the things that they normally had access to, right the things that supported them social support and emotional regulation.

Rachel Goode: You know, treatment and care, people who are used to you know, you're used to seeing your provider in person, and so you had to switch to seeing them online that was huge! And at the same time, you were dealing with increased risk, right. Your activities or structure was disrupted and you were fearful, because you know you were concerned that you may get COVID-19.

Rachel Goode: And so the combination of this really cause an increase in eating disorder risk and symptoms. However, the challenge with much of our research in this area is that it's been done in predominately White samples, and we haven't learned that much about how COVID-19 has affected Black Americans. So my team, and I, we did a study, where we interviewed 20 Black women who reported binge eating behaviors during the first wave of the COVID-19 pandemic. We wanted to see what the impact on COVID-19 for them. And so what we saw, so our sample of individuals are about 43 years of age, reported about five, five, between five and six objective binge eating episodes, have very limited episodes of any purging behaviors ,and had achieved about you know, a bachelor's degree or higher.

Rachel Goode: So we came up with several things from this interview study and I'm just going to present them briefly here.

Rachel Goode: Participants often talked about how difficult it was to manage their eating, as they were in their home environment all the time and that felt very triggering for them.

Rachel Goode: Participants also noted that it was difficult, because there was no structure in the routine and so it made eating episodes continue, and there was no stopping.

Rachel Goode: We saw participants struggle with increased loss of control binge eating episodes and also found it challenging to go to grocery stores and find foods that they were used to having not be available for them and found themselves relying on food as a coping tool, even though they were trying, maybe to make some changes in the behavior.

Rachel Goode: They found during the distress that popped and came up from COVID-19, they found that using food to cope with something that was really still meaningful to them.

Rachel Goode: So one of the participants said it this way, “I find myself eating ice cream and cookies two or three times a day and at bedtime, which are things I never did before COVID.”

Rachel Goode: And before COVID, but I can eat a bite of any dessert and be completely satisfied, since COVID I have wanted to eat the whole desert, that's different.”

Rachel Goode: “It's very different and I have been this way for years, when it came to desert one by enough satisfied done. Since COVID, I'm not satisfied with anything and God it feels like I’m never done.”

Rachel Goode: Another participant noted, “I can't do what I want to do. I can’t hang out. I can't see friends. I can't go to a comedy show. I can't go out, so I'm eating.”

Rachel Goode: Right. And so these quotes, I hope they illustrate just what the experience was like for some of these women who were struggling with disordered eating before the pandemic and then had to navigate it during COVID-19.

Rachel Goode: We also know that there are disparities in treatment access. And these are things that are really concerning. So, what we've seen is that Black Americans are less likely to receive treatment for disordered eating and then, when they are in treatment.

Rachel Goode: They're more likely to drop out. Now some of the reasons for the dropout might be often we see that when Black Americans get engaged in treatment for disordered eating they might make changes really quickly. Okay, and so they might all of a sudden start to feel better.

Rachel Goode: And that means that they may feel more comfortable not moving forward or not feel like it's necessary. There also might be a challenge with feeling comfortable with the provider and not feeling like maybe some of their concerns have been heard.

Rachel Goode: So these are just some ideas, we don't fully know why they might be more likely to drop out of treatment, but I think we can infer that some of these spaces may not always have been, as accommodating or as culturally relevant as maybe some of these participants might have needed. And so, that might also have contributed to some of the challenges.

Rachel Goode: So when we see some of the treatment access, this charge of this study was done, where they were assessing what are you know, our Black and White women as likely to receive treatment for disordered eating.

Rachel Goode: And so here, we see that Black and White women, Black women are the black, I mean the grey.

Rachel Goode: And then the White women are the pink. And so, they're very likely to receive treatment for a weight problem, but you see that White women are three times more likely to receive treatment for disordered eating.

Rachel Goode: And I think this has to do with understanding what an eating disorder is, and often eating disorder treatment has been in specialty eating disorder clinics.

Rachel Goode: And so Black Americans aren't, that's not really the place that we go to receive care. A primary care setting is probably a more likely place that we receive care. And so these, these, problems and these issues are continuing.

Rachel Goode: We also see that there's just some disparities in lifetime service utilization when it comes to eating disorders, and we just see differences across race, there are significantly higher rates of service utilization in White populations, compared to Black, Latin X, and Asian populations.

Rachel Goode: So this was a study that was done in about 30 multi-ethnic women about where the authors were looking to see why, right. What are some of the reasons that these individuals aren't seeking treatment?

Rachel Goode: And so, you see what the most common reason is financially, right, financial barriers. You also see that lack of insurance, it has been you know challenging to pay for this treatment worried what people cannot help.

Rachel Goode: Not knowing about the resources, you see concerns about counselors not being the same ethnic background. So things that we've talked about some of the things that are affecting, just being able to feel comfortable seeking care.

Rachel Goode: We also have to recognize the world clinician bias. And so, this study examined this was a psychologist and they were giving them case studies so they were presented with identical case studies, where they had to demonstrate the disorders and really begin to understand and identify the disordered eating symptoms. And so clinicians were asked identify if the woman's eating disorder behavior was problematic and White sample and Hispanic women and Black women.

Rachel Goode: And so 44% were able to identify the White woman's eating behavior, and Hispanic about 41%, with a Hispanic woman's behavior as problematic. But you see 17% were able to identify the Black woman's eating behavior as problematic. And so that is very concerning, because what this is showing is that we don't know what eating disorders look like in non-white populations. In particularly, in Black populations clinicians haven't really received the training and don't really understand what it looks like, so we might be missing a lot of eating disorders, because it may not come in the package that many are used to seeing.

Rachel Goode: So what are some of the reasons? I think one of the biggest reasons we see is that the patient is not underweight.

Rachel Goode: And so what we see in our previous research is that when Black patients present for eating disorder treatment they often have higher BMIs than White patients, White participants.

Rachel Goode: And so immediately that often throws off because then clinicians might have some perceptions themselves misperceptions that eating disorders are only anorexia.

Rachel Goode: They might be individuals are only preoccupied with a thin ideal. And if the patient meets BMI criteria for obesity, the good clinician might feel more comfortable recommending weight loss, or discussing Type 2 diabetes right, that might feel more appropriate at that time, meanwhile, the eating disorder is hiding in plain sight.

Rachel Goode: And they are not getting the focus and the help to really begin to call it out and even sometimes the clinicians acknowledge we don't have the training and so.

Rachel Goode: NCEED has been working hard to develop a screening tool, SBIRT-ED to begin to kind of fix that problem. But we still need more because the issue really is that we don't know what eating disorders look like in non-white populations until that is really dealt with and we're going to continue to miss people who really could use our help.

Rachel Goode: So this is an example of a screen or something that could be used in the primary care setting, and some do use, just a seven question screener that often is very quick and could be given to kind of assess eating behaviors and patterns within the last three months. So, the first several questions just ask about any episodes of overeating and whether there was distress about overeating. And then it goes down and examines individuals felt like they had loss of control.

Rachel Goode: Did you continue to eat when you're hungry? Did you, you know feel disgusted with yourself, and then they assess for any compensatory behaviors. And so, this might be a quick screening option that might be helpful.

Rachel Goode: For those of you who are in practices and you need to have a screening tool for eating disorders, you might want to find something like this that could really be helpful to you.

Rachel Goode: So now I'm going to take time some time to examine some treatment considerations.

Rachel Goode: And just begin to help us think about if you are a provider, and you are working with individuals who are managing Black individuals, who are managing eating disorders just some things that you might be able to do just to kind of switch the frame a little bit, and prepare yourself to really begin to treat this population.

Rachel Goode: So one of the things, I saw recent texts that came out was treating Black women with eating disorders by Charllynn Fuller and Mazella Small offered the importance of what kind of questions

do we ask in assessment. And often our questions are very colorblind, but if we were to focus on some culturally relevant factors things that we know, we might ask a few different questions.

Rachel Goode: Bringing in the role of race, bringing in hair, right, spirituality, gender, how those things have shaped body image.

Rachel Goode: What how has racism influenced the way that you relate to your body and experiences that might have influenced or shaped your relationship with food? You know ask them questions about messages that they tell themselves about food and eating patterns, also factors related to oppression that your client might discuss to you. Does your client identify with being all things to others? Is it difficult for them to ask for help? Is it difficult for them to speak their truth and be able to say when they've had enough? Understand the triggers that might be present to eat, or to not eat? See these are things that sometimes we haven't really done a very good job of bringing in to our assessment.

Rachel Goode: And because we haven't asked certain questions, we may not have gotten the answers that we've needed to really begin to understand what disordered eating looks like in this population.

Rachel Goode: Also, if we're going to do a comprehensive assessment right, we're going to understand the history of their eating patterns and their relationship with food and the role of culture. I can't say this enough. To really begin to unpack and understand what, how their culture has influenced how they relate to food and what they've learned about how they relate to food.

Rachel Goode: What kind of stress they might be feeling, any acculturative stress. And so individuals probably wouldn't say it in this way, but if you invite the role of race into the room, make it clear, as a clinician that that's something, that experience is something that you find that is critical to talk about. It might provide an opportunity for you to just kind of examine what it has been like if they've had experiences, where they have been you know, the only Black person or in a sea of majority white spaces; and how that might have impacted their eating behaviors, in their relationship and perception of their body.

Rachel Goode: Due to our previous discussion, earlier in this presentation, we know just to assess the presence of food insecurity, poverty, previous trauma and we know that eating disorders, often are coupled with other comorbid mental health concerns and to also assess the presence of those and even comorbid with physical health concerns. Whether it be obesity, Type 2 diabetes. What we see is often there's disordered eating present within both of those as well. And then to examine cultural biases and beliefs that might be facilitated of disordered eating and might get in the way of when it comes to like cultural ideas about body type, preferences, things that might cause weight stigma, what that looks like in their cultural contexts.

Rachel Goode: So I think it's important to, especially as clinicians of color when we are working with other Black clients, you know we have to share a culture between us. But sometimes I think we have to remember that misunderstanding and bias can exist between us as well.

Rachel Goode: And so the challenge, when you share a racial background, with the client, you will often mistake your experience for oppression. Your worldview might be swapped, you might assume, right, that the client has your same experience, because you all share skin color.

Rachel Goode: And so it's important to not do that right, and to take the time to understand and examine the clients experience with racism, sexism, and gender identity concerns; recognizing that it's likely different from your own and you do not know just because you might share that similar racial identity.

Rachel Goode: It's also important to examine your racial identity status right. We all have a developmental trajectory, we are, and we have been kind of processing and coming to terms with our racial identity within the context of this country.

Rachel Goode: And so, think about your racial identity status and how you might be able to kind of understand what your clients is and the combination of those two and what the impact of those two together, how that might really influence the relationship.

Rachel Goode: And, as always it's important, I think, to recognize it bias is everyone is equally as capable of bias and to be able to understand and do your work, so that you can have continual growth with your clients in this way.

Rachel Goode: For White clinicians who might be treating a Black patient right, the first thing I think it's so helpful to do is to examine your racial identity, right. And, to have done that work, where you're thinking about your racial identity and its impact on you.

Rachel Goode: And to verbally, to say the words, how you would like you know you acknowledge the role of the influence of racism and you want to learn and just open the door for the client to discuss their experience with the isms, knowing that they may not want to talk about it. But your job is just to be able to say and show that you are someone who they can talk about it with.

Rachel Goode: And as you continue to build a journey, where you're uncovering your areas of bias and your growth edges, this might be an opportunity for you to feel more comfortable inviting your client's right to share on the impact of racism in their lives.

Rachel Goode: And then you think about your office space, what it likes when clients come in your space and you're sending messages all the time.

Rachel Goode: Right, how you can begin to set an atmosphere for clients feel even again? I know we do a lot of things telehealth, but we might have reason we kind of have to physically come and see you, and how you even think about your social media platform or your website.

Rachel Goode: How are things that you're advertising, or language that you're using that signals the clients?

Rachel Goode: That hey, you are concerned and you're a safe place to go to and if you're not acknowledging race or talking about it or not mentioning it at all.

Rachel Goode: It does often have the opposite impact, and it may not communicate what you think it's communicating. I think sometimes clinicians may feel like well, I want everyone to feel that it's a colorblind space. And it feels safe, and it doesn't often when you don't talk about race, it communicates that you may not see the other person and you may you know not really see that in me and there's nothing to be ashamed of but, so we have to show that we feel that way because it won't be assumed.

Rachel Goode: So these are some various psychological treatments for disorders that have a significant literature. So Cognitive Behavioral Therapy-Enhanced probably has the largest research literature on its effectiveness in treating eating disorders and I have listed all of these, recognizing that we know for Black clients I think it's clear that we have quite a deficit when it comes to.

Rachel Goode: The effectiveness, we just don't have as many studies, as we should, on the effectiveness of these treatments for Black Americans who are managing disordered eating.

Rachel Goode: But we do know a couple things so this was a study that was done in 2019 and they had about 579 participants, and so they looked across all of their, all of their participants who had participated in their research trials. And so, what we see here are different forms of treatments to reduce binge eating.

Rachel Goode: So in the blue, this is behavioral weight loss treatment right, that's one very common treatment that we have seen that has been effective in the literature, to reduce binge eating. Even though I know many have their feelings about behavioral weight loss, but nonetheless it is often a treatment that is used to reduce binge eating. Cognitive behavioral therapy is here in orange, and this was a combination of medication and other behavioral weight loss and cognitive behavioral psych, a combo treatment.

Rachel Goode: And then, this yellow is the control group. And so, what we see in Black participants they don't have the shaded so they're just the solid bar.

Rachel Goode: And so, when Black participants are in these programs, we see that they are doing better than the White participants. Their symptoms, especially here in behavioral weight loss, their symptoms of their binge eating you know their, this is their remission as it goes up right, so how percentage of remission for the symptoms are going away and we see that the Black patients as they're getting this care their symptoms are remitting, right?

Rachel Goode: They are, they're doing better and what we see is that I think what we can infer from this is that we already have treatments that have been found to be effective for other populations. But we just have not tested them in Black populations. But, this study may lead us to suggest that some of these trainings that we already have may work well. So, our work is to find out how we can get individuals to engage in treatment, more, so that they can receive more of they can just receive the help that they need.

Rachel Goode: So this was a study where my lab we have been working to see kind of the feasibility of a different approach and helping participants, this was an appetite awareness training that was developed by Linda Craighead, a psychologist at Emory.

Rachel Goode: And the program is to help participants to honor and adhere to their biological signals of hunger and satiety. And, so my team and I were wondering if you know, since we know that Black Americans, my White women especially might use food as a coping and so, if we can help them relearn their biological signals of hunger and satiety and kind of reconnect with their bodies and begin to eat, you know and just kind of again bring that reconnection. And so, what we were able to see is that in our study we have 31 Black women with obesity reported at least monthly binge eating over the last three months.

Rachel Goode: And so we were just going to see do they like this program right, is there the potential of really using this as a treatment for binge eating in this population?

Rachel Goode: And so what we saw is that participants, they did like it. They were retained, and participants who were in the appetite awareness training part had greater decreases in binge eating scores.

Rachel Goode: We also have to think about again, if we know the individuals may not be coming in to treatment, how can we get self-help resources to them?

Rachel Goode: And to recognize some of these texts, something we have to think about creatively, how we can package, it in a way, that can reach others. But I think COVID-19 has helped to see, we have to change the idea of treatments being you know, in an office and recognize the digital platform is just a plethora of help. And so, how can we package these treatments into a way that we can reach people digitally right and we can help people. And then, if those who won't come in, how can we give them access, especially if it's a binge eating concern.

Rachel Goode: We've seen in the literature that self-care resources can be really helpful and effective to help reduce binge eating behaviors, but we have to find a way to begin to package that so that Black Americans and those who have been underserved by our current programs can get access to those treatments.

Rachel Goode: And so, this is just a model when we think about the levels of intervention and what we know about helping Black Americans as they're managing eating disorder so at the individual level right if you are, you have the opportunity to practice on the individual level.

Rachel Goode: You know some of the first things that we're going to need to do is educate about eating disorders, because that providing that psychoeducation, it cannot be, you cannot do that enough because I often found among individuals in my research studies, that's usually the first place to start because people just aren't familiar with eating disorders.

Rachel Goode: And then, to provide just awareness on increasing alternative coping skills, because food is often used as a coping strategy, and so, to be able to develop alternative coping skills to manage emotions.

Rachel Goode: And then to begin to provide acknowledgement, support, validation for experiences of stress, racism, micro aggressions, and trauma because we know in the research that this is likely to influence eating disorders in this population.

Rachel Goode: We have to also consider on the family level just what food means and the expectations that might have been presented on what it means to you know kind of our models for eating.

Rachel Goode: And you know we often laugh about having to clean your plate, and some of our expectations that we might have received from our family members. These things really shaped eating behavior and to begin to unpack that system.

Rachel Goode: And if you have the opportunity to work with family to understand how to re-socialize and help family members to create a different environment around eating.

Rachel Goode: We also have to help our providers right, to understand that eating disorders may not develop as a response to the overvaluation of shape or weight and there's other things, and because of racial stereotypes

Rachel Goode: it's easy to miss eating disorders, because, just like the young woman was saying in the video earlier, it is easy to acknowledge that these video that.

Rachel Goode: We just don't know what it looks like and other population, and we have missed people because of that.

Rachel Goode: And also improve just access to culturally relevant definitions and norms of disordered eating, because it is not the same thing across races.

Rachel Goode: And then in our systems right, how can we recognize if we know that Black Americans are often going to primary care centers more than any other place, how can we offer treatment for eating disorders in those places and include assessments for eating disorders in programs that are going to be geared for weight management. Because likely you will see a Black American engage in treatment for weight, before they will engage in treatment for eating disorders, and so we have to take the opportunity to use those spaces as potential treatment for disordered eating as well.

Rachel Goode: So just a summary, you know we have very limited evidence-based treatment for eating disorders among Black and African American population so because of that we're going to have to there's going to be changes that are going to be required in setting, in our recruitment strategy, and just how we can understand the factors that, the relevant factors in treatment, and then we think about what we know about equity and we might have to shape our treatments differently if we're going to reach people who have been underserved, have not been included. And we haven't, they haven't been the norm as we've been building our treatment, so it leaves a great opportunity for our research field to and our clinicians to begin to remodel, right. Build differently, as we think about opportunities to treat eating disorders and Black Americans.

Rachel Goode: So, in summary there's similar or higher prevalence of binge eating, particularly with bulimia nervosa and binge eating disorder in Black Americans.

Rachel Goode: However, we continue to see disparities in access and retention to treatment, but we are learning that it's bigger, right. It's not just about being the desire for thinness, but we recognize these other factors, poverty, racism, and acculturative stress may also contribute to the development of eating disorders in this population.

Rachel Goode: And so, because we have these limited evidence based treatments, we have to be creative about building and modeling something new.

Rachel Goode: And we have to continue as researchers to examine the prevalence and the nature of eating disorders in various racial and ethnic populations, and examine differences in treatment response.

Rachel Goode: So thank you all for presentation and for listening, and I look forward to answering any questions.

la-shell_johnson@med.unc.edu: Thank you so much again Dr. Rachel Goode for a wonderful presentation. I just wanted to give you guys a few quick updates before we move into question and answers. We will be sending out the PowerPoint slides tomorrow.

la-shell_johnson@med.unc.edu: Ms. Courtenay Pierce will send those out, and you'll also receive instructions in that email regarding NAADAC and continuing education credits from the APA. How you are to redeem those and the respective persons to email. You'll also receive an evaluation form from Mr. Cory Ware from the African American Behavioral Health Center of Excellence. I'll now move into our

question and answer segment, if you have any questions, please list them in the Q and A box. I'll start to read those now.

la-shell_johnson@med.unc.edu: and also to mention this webinar will be available via the NCEED training Center at www.NCEEDUS.org within one week from today. Any unanswered questions will be sent via email one week from today to all of the participants in today's webinar.

la-shell_johnson@med.unc.edu: So the first person asks, “can we have the link to the clip?” Dr. Goode, I think that's the clip that you showed within the presentation.

Rachel Goode: Yes, I might I think I can share that so I'll try to share that with you La-Shell.

la-shell_johnson@med.unc.edu: Thank you, and then the next question asks, “What are your thoughts about prevention and identifying people at risk of developing a disorder?”

Rachel Goode: Hmm yeah that's an important question, because I think we do need to shift to that place where we are kind of knowing if individuals might be struggling. So, I think about in a primary care setting individuals one thing we've seen in the research is that.

Rachel Goode: Often, maybe the year before an individual goes in for weight management, there might be a period of rapid weight gain so that is often a sign that there might be disordered eating present.

Rachel Goode: I think there's also just, just maybe just sometimes people are very anxious about some of their eating behaviors. What we see is that in our country when individuals engage in kind of dieting. Sadly, often dieting is kind of what precedes the development of an eating disorder. And so, although we know that there are other reasons that is still very, a kind of, sometimes individuals were engaged and they engaged in a like a yo-yo dieting, and they kind of are gaining weight, and then they're losing it again and gaining weight. It's easy to kind of just go slowly, you might be in a healthy weight management program, it’s easy to also get into periods, where you're doing some restriction.

Rachel Goode: And so, when we see individuals restricting their eating, it can also really influence the type of rubber band effect, and they can go the other way and it can lead to some more binge eating behavior so that's often someone's on a restrictive diet. That's another place to watch that may be for the development of disordered eating.

la-shell_johnson@med.unc.edu: Thank you so much for that, that they're good. The next question asks, “How do you suggest that White providers or parent coaches reach out to and connect with individuals in its very segregated area, for instance, Western North Carolina?”

Rachel Goode: Um, so I always think it is good, when, if you are the White provider and you're trying to kind of enter a community that you're not a part of. I think it's always good to go and find gatekeepers in the Community and to build a relationship with them first because, in order for you. To get access to anyone truly, people are going to have to know that you are okay. And someone else is going to have to, you can't do that yourself, someone else is going to have to vouch for you.

Rachel Goode: And so, I think it's important for you to develop a relationship, because there are probably people already in the community who are providing resources, who are shared Who are these things, probably already exist and it's important to partner with some individuals who are already helping others and to yeah, and to begin to kind of just create, just trust, and a relationship and then think of it as you helping other people in joining, and showing up to spaces, where you might be the only one in that space and beginning to kind of just put yourself out there and want to meet people, and want to collaborate and it might be a little challenging at first, but it's just you're going to have to demonstrate that we can trust you and it's going to be challenging without some buy in from the community.

la-shell_johnson@med.unc.edu: Thank you so much for that Dr. Goode, I think we can get two more questions and the next question asks, “How do we let people know in the Black community when services are available for eating disorders?”

Rachel Goode: Yeah oh, my goodness, so I think its first how, how do we have a conversation where we even know how to present eating disorders right and, and be able to talk about what an eating disorder is. And, so I can think of various, I've been on a couple panels, where they just kind of had a talk session.

Rachel Goode: Where you just invite people often when I advertise for my studies, I invite people to talk about their experiences with a loss of control eating, emotional eating experiences. Just feeling out of control, around food like there are certain terms that I’ve found that just kind of resonate with people, people know what that means versus just binge eating or bulimia nervosa that may not resonate.

Rachel Goode: So we need to kind of meet the people where they are, and lets. But people can talk about their eating behaviors. Because if you're managing with disordered eating it's disturbing to you, it bothers you, right. And so, you know that feeling. And so creating spaces, I think, where you can help people kind of talk about that and then providing just information. I love social media in that way,

because it's a way that in our lab we've been able to, you know, just kind of link people to things that are going on.

Rachel Goode: Linking just various clips, just opportunities to show, just make it relevant to individuals. And, if someone can share their story, I think that's probably the most powerful testimony because people are able to relate to what an individual has been going through in that way.

la-shell_johnson@med.unc.edu: Thank you so much for that Dr. Goode. And I'll go ahead and mention our last question before we wrap up. The remaining questions will be sent to Dr. Goode, and she'll send responses via email within one week.

la-shell_johnson@med.unc.edu: "How do we educate the local Black community on eating disorders and the need to refer?"

Rachel Goode: Yeah, yeah, I think so first we have, we have to just name it. Name the misconception, you know eating disorders are not just a White woman's disease.

Rachel Goode: We, I say that over and over again. We all can have eating disorders. And so, we have to name the misconception, and then they're going to have to see, we're going to have some brave people. And, I know there are individuals who have overcome an eating disorder, who would like to help others. And, I think often hearing from people who look like you and who have kind of dealt with this, who have walked this journey and come out on the other side is often a tool that is really powerful that people can kind of say I see me in you. Right, representation matters. We know that, and so we know that we're going to have to be able to help people see themselves in it.

Rachel Goode: And so, if we don't often see our images, we don't have images. And right, and we I love that we have had like I think of a chia read, who has come forward and talks about her struggle with eating disorders. Other writers, who have talked about their struggle with eating disorders. And, I think that's probably something where we can tack on to someone who looks like us, and we're like yeah, I get it. You understand what I'm talking about. I think that's going to help us to be able to treat and make people more aware.

la-shell_johnson@med.unc.edu: Thank you so much for that Dr. Goode. I want to thank you all for joining today's session. We will send contact information for Dr. Goode to you all with the responses for the answer questions that weren't addressed today. We will also provide you with the slides tomorrow. Dr. Goode, do you have any closing remarks that you'd like to share?

Rachel Goode: No. I'm grateful to be here and thank you all so much.

la-shell_johnson@med.unc.edu: Okay. Thank you so much, and we'd also like to thank our partners. Dr. Tyus and Mr. Cory Ware at the African American Behavioral Health Center of Excellence for their collaboration in today's webinar. Thank you all for joining, and please remember that you will be able to access this webinar via to NCEED Training Center within one week from today. Thank you so much, thank you.