



Inclusive Eating Disorder Care

Things to consider when building inclusive care into eating disorder treatment centers.

The ANAD Approach

The National Association of Anorexia Nervosa and Associated Disorders

Disclaimer: This guide was developed in response to gaps we've noticed in regards to inclusivity in the currently available eating disorder treatments. Our team conducted our own research, which is referenced in this guide. This guide is not exhaustive and was not developed by DE&I specialists, but we share it in the hopes that treatment centers can use it to continue the pursuit of equity in their treatment of eating disorders. Any questions can be directed to our Executive Director at kristen.portland@anad.org.

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THE ANAD APPROACH

HEALING THE EATING DISORDER COMMUNITY THROUGH COMPASSIONATE ACTION

At ANAD, we believe in a comprehensive APPROACH to eating disorder treatment and recovery:

Acceptance of everyBODY

Accept yourself, accept others. Every individual is unique and beautiful, yourself included.

Prioritize self-care

Learning to engage in self-care is not selfish. It is self-preservation, an act of love towards your body and mind. Give yourself permission to engage in self-care.

Parents, spouses, loved ones

Don't go it alone. Support dramatically improves recovery, buffers stress, and enhances the quality of life and well-being. Accept love and support, as well as give love and support.

Recovery

Full recovery from an eating disorder is possible, but it takes time. Have patience with yourself.

Options

Effective treatment often requires a spectrum of treatment options. ANAD provides an array of free services, consistently explores new ideas and innovative approaches, and provides the opportunities for people to share and learn from others who have recovered.

Aftercare

We believe post-treatment support is crucial. Strengthen your eating disorder recovery by participating in ANAD's many programs.

Compassionate care

Having an eating disorder is not a choice. Eating disorders are complex, serious, biologically-based illnesses. Let's move away from shame and blame. You are not a diagnosis, a disease, or a disorder, but rather a human being that deserves respect and understanding.

Hope, help, healing

Walking alongside you in your journey, ANAD can help you transform your life. It is our honor to support you through your recovery.

DIVERSITY, EQUITY, ACCESSIBILITY, AND INCLUSION STATEMENT

ANAD is a diverse, inclusive, and equitable organization where all employees, volunteers and beneficiaries are valued and respected, no matter their gender, race, ethnicity, national origin, age, sexual orientation or identity, education, body size, or disability. We are committed to a nondiscriminatory approach and provide equal opportunity for employment and advancement in all of our departments, programs, and workplaces.

We respect and value diverse life experiences, and ensure that all voices are valued and heard. We're committed to modeling diversity, equity, accessibility, and inclusion as a leading nonprofit in the eating disorder field.

RESEARCH

BIPOC (BLACK, INDIGENOUS, AND PEOPLE OF COLOR)

- Black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior, such as bingeing and purging.¹
- Hispanic people are significantly more likely to suffer from bulimia nervosa than their non-Hispanic peers.¹
- Asian American college students report higher rates of restriction compared with their white peers and higher rates of purging, muscle building, and cognitive restraint than their white or non-Asian, BIPOC peers.²
- Asian American college students report higher levels of body dissatisfaction and negative attitudes toward obesity than their non-Asian, BIPOC peers.²
- BIPOC are significantly less likely than white people to be asked by a doctor about eating disorder symptoms.¹
- Latina and Native American women are less likely than white people to receive a referral for further evaluation or care no matter how severe their symptoms of an eating disorder.⁴
- Perceived racial discrimination in healthcare is most common among Black people (12.3%), followed by Native Americans (10.7%) and white people (2.3%).⁵
- Black people, Hispanic people, and some Asian people, when compared with white people, generally have lower levels of health insurance coverage, with Hispanics facing more barriers to health insurance than any other group.⁵

1. "People of Color and Eating Disorders" by the National Eating Disorders Association

2. "Eating Disorder Symptoms in Asian American College Students" by Rachel C. Uri, Ya-Ke Wu, Jessica H. Baker, and Melissa A. Munn-Chernoff

3. "Race, Ethnicity, and Eating Disorder Recognition by Peers" by Margarita Sala, Mae Lynn Reyes-Rodríguez, Cynthia M. Bulik, and Anna Bardone-Cone

4. "We Are Failing at Treating Eating Disorders in Minorities" by Kristen Fuller, MD for *Psychology Today*

5. "Perceived Discrimination and Privilege in Health Care: The Role of Socioeconomic Status and Race" by Irena Stepanikova, PhD and Gabriela Oates, PhD

RESEARCH

LGBTQ+ (LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER)

- Gay men are seven times more likely to report bingeing and twelve times more likely to report purging than heterosexual men.¹
- Gay and bisexual boys are significantly more likely to fast, vomit, or take laxatives or diet pills to control their weight.¹
- Transgender college students report experiencing disordered eating at approximately four times the rate of their cisgender classmates.²
- 32% of transgender people report using their eating disorder to modify their body without hormones.³
- 56% of transgender people with eating disorders believe their disorder is not related to their physical body.³
- Gender dysphoria and body dissatisfaction in transgender people is often cited as a key link to eating disorders.²
- Non-binary people may restrict their eating to appear thin, consistent with the common stereotype of androgynous people in popular culture.²
- Best practices for treating transgender people with eating disorders include acknowledging the complex nature of the body, validating and affirming their identity, continually pursuing clinical training, supporting access to transition, and facilitating access to care.³
- Common barriers to treatment for LGBTQ+ people include a lack of culturally-competent treatment, lack of support from family and friends, and insufficient eating disorders education among LGBTQ+ resource providers who are in a position to detect and intervene.⁴

1. "Eating Disorders in LGBTQ+ Populations" by the National Eating Disorders Association

2. "Eating Disorders in Transgender People" by Lauren Muhlheim, PsyD, CEDS for *Verywell Mind*

3. "Transgender Clients' Experiences of Eating Disorder Treatment" by Mary E. Duffy, Kristin E. Henkel, and Valerie A. Earnshaw

4. "We Are Failing at Treating Eating Disorders in Minorities" by Kristen Fuller, MD for *Psychology Today*

RESEARCH

PEOPLE WITH DISABILITIES

- Women with physical disabilities are more likely to develop eating disorders than other women.¹
- 20–30% of adults with eating disorders also have autism.²
- 3–10% of children and young people with eating disorders also have autism.²
- 20% of women with anorexia have high levels of autistic traits. There is some evidence that these women benefit the least from current eating disorder treatment models.²
- ADHD is the most commonly missed diagnosis in relation to eating disorders and disordered eating.³

1. “The Connection Between Disabilities and Eating Disorders” by Montecatini and Eating Disorder Hope

2. “Trajectories of Autistic Social traits in Childhood and Adolescence and Disordered Eating Behaviours at Age 14 Years” by Dr. Francesca Solmi, Francesca Bentivegna, Helen Bould, William Mandy, Radha Kothari, Dheeraj Rai, David Skuse, and Glyn Lewis

3. “ADHD and Disordered Eating” by James Greenblatt, MD and Walden Behavioral Care

PEOPLE IN LARGER BODIES

- Less than 8% of people with eating disorders are medically diagnosed as “underweight.”¹
- Larger body size is both a risk factor for developing an eating disorder and a common outcome for people who struggle with bulimia and binge eating disorder.²
- People in larger bodies are half as likely as those at a “normal weight” or “underweight” to be diagnosed with an eating disorder.³

1. “Eating Disorders by the Numbers” by Millie Plotkin, MLS and F.E.A.S.T.

2. “Obesity & Eating Disorders” by the National Eating Disorders Collaboration (Australia)

3. “Eating Disorders Common in Overweight, Obese Young Adults” by Kristen Monaco for *MedPage Today*

LIVED EXPERIENCE SURVEY

OVERVIEW

In August 2020, ANAD issued a survey to our community to learn more about their lived experience. The survey was intended for anyone who had received treatment for an eating disorder in the past five years, including those still in treatment. The questions were as follows:

- While in treatment, did you ever feel uncomfortable disclosing your race or ethnicity?
- While in treatment, did you ever feel uncomfortable disclosing your sexual orientation or gender identity?
- While in treatment, did you ever feel uncomfortable disclosing a disability?
- While in treatment, did you experience discrimination from staff, clients, or visitors based on your race or ethnicity?
- While in treatment, did you experience discrimination from staff, clients, or visitors based on your sexual orientation or gender identity?
- While in treatment, did you experience discrimination from staff, clients, or visitors based on a disability?
- Is there anything else you'd like to share about your experience?

DEMOGRAPHICS

- 11% of participants identified as BIPOC.
- 39.5% of participants identified as LGBTQ+.
- 12% of participants identified as nonbinary or gender nonconforming.
- 28.5% of participants reported a disability.
- 4% of participants reported having autism spectrum disorder.

LIVED EXPERIENCE SURVEY

RESPONSES

Responses were submitted and recorded anonymously. This allowed participants the opportunity to elaborate on their answers to the extent they felt comfortable. Some of those responses are included here.

While in treatment, did you ever feel uncomfortable disclosing your race or ethnicity?

- “Yes. I was the only black person in the room and my ED was due to racial trauma.”
- “Yes, how my race/ethnicity affects my eating disorder was never addressed in my treatment and therefore not explored by myself, openly or otherwise.”
- “No, but I didn’t like how some comments were said about race and nothing was addressed.”
- “It was uncomfortable at times being the only minority.”

While in treatment, did you ever feel uncomfortable disclosing your sexual orientation or gender identity?

- “Yes. I’ve always felt uncomfortable saying I’m bisexual to my doctor because I was afraid it would impact my level of care.”
- “Even though I put on my entrance forms that I was non-binary, I was assigned to the female-only groups and felt very uncomfortable advocating for myself.”
- “Yes, it felt hard to assert my they/them pronouns in spaces that were largely framed as women’s spaces (intentionally and unintentionally).”
- “Yes. It made recovery next to impossible because I couldn’t talk about a large part of my identity and experiences.”

LIVED EXPERIENCE SURVEY

RESPONSES

While in treatment, did you experience discrimination from staff, clients, or visitors based on a disability?

- “Yes. My additional illnesses were treated as a liability.”
- “Yes, by clients. I was bullied even during groups and there were only two staff members who cared to address it.”
- “When I last tried to obtain treatment, I was refused by almost every facility because they said they would not accept an autistic patient. I was unable to get care.”

Is there anything else you'd like to tell us about your experience?

- “Change comes from the top.”
- “Patients should have the option to opt-in to gender-neutral rooming if they wish.”
- “It was always obvious to me that treatment was tailored to the success and aid of a certain demographic: thin white girls.”

REPRESENTATION

Our survey also touched on the subject of representation within eating disorder treatment. The results are as follows:

- 85.3% of participants felt their race and ethnicity were adequately represented on staff.
- 68.8% of participants felt their sexual orientation and gender identity were adequately represented on staff.
- 54.2% of participants felt their disability was adequately represented on staff.

CONSIDERATIONS FOR INCLUSIVE CARE

INTRODUCTION

ANAD's considerations for inclusive care are a culmination of research and collaboration with treatment centers across the country. The Health Equality Index (HEI), established by the Human Rights Campaign, was used as a frame of reference for these considerations, specifically for those regarding LGBTQ+ issues. These considerations are not intended to fulfill the need for diversity & inclusion training, but rather a framework for providing inclusive care.

Treatment centers who participated in these conversations, as of the publication of these recommendations, include Center for Discovery, EDCare, Eating Disorder Solutions, Eating Recovery Center, The Emily Program, McCallum Place, Montecatini, Reasons, Renfrew Center, Rogers Behavioral Health, Timberline Knolls, Veritas Collaborative, Walden Behavioral Care, and Yellowbrick.

CONSIDERATIONS

1. Treatment centers seeking to broaden their client base to include more BIPOC, LGBTQ+, people with disabilities, and people in larger bodies must also prioritize diverse hiring so that clients will see themselves represented in the staff who treat them.
2. Treatment centers must establish a non-discrimination policy to protect BIPOC, LGBTQ+, people with disabilities, and people in larger bodies. Policy should be available on the center's website and communicated to all staff and clientele. Policy should include the language "sexual orientation" and "gender identity and expression" in addition to race, ethnicity, religion, and disabilities.

CONSIDERATIONS FOR INCLUSIVE CARE

CONSIDERATIONS

3. Treatment centers should include accessible, all gender restroom(s) with clear posted signage. At minimum, clients should have the option to request a private and accessible, all gender restroom.
4. Facilities must be accessible for people with disabilities and people in larger bodies.
5. Treatment centers must be prepared to address and correct racist, fatphobic, homophobic, and otherwise discriminatory language among staff and clients, even when that language is not directed at a particular person. This includes misgendering and micro-aggressions. Diversity & inclusion training may be necessary to develop the understanding of what constitutes racist, fatphobic, homophobic, and otherwise discriminatory language, including misgendering and micro-aggressions.
6. Electronic health records (EHR) should offer explicit options to record a client's current gender identity, as well as the sex they were assigned at birth.
7. If a client's name in use differs from their legal name, EHR should prominently display the client's name in use and mark it as such.
8. EHR should also record the client's personal pronouns.
9. Clients and staff must be referred to by their name in use and their personal pronouns. If a client or staff member's name and pronouns are unknown, their name and pronouns must never be assumed. Singular "they" and "them" are considered neutral pronouns and can be used when a person's personal pronouns are unknown.
10. Treatment centers should establish committees or task forces specific to issues of equity, diversity, and inclusion. These groups should strive for representative diversity to the fullest extent possible and work towards providing more inclusive care (as described in this guide) for BIPOC, LGBTQ+, people with disabilities, and people in larger bodies.

CONSIDERATIONS FOR INCLUSIVE CARE

CONSIDERATIONS

11. Treatment centers should consider implementing and promoting unique scholarship opportunities for BIPOC, LGBTQ+, and people with disabilities. These populations experience unique financial barriers to receiving treatment such as lack of insurance.
12. Treatment centers should consider funding critical research regarding eating disorders among BIPOC, LGBTQ+, people with disabilities, and people in larger bodies.
13. Treatment centers should provide links on their center's website to health education or service resources specific to BIPOC, LGBTQ+, people with disabilities, and people in larger bodies.
14. Treatment centers using identity symbols such as the LGBTQ+ pride flag on their website or in marketing materials should be able to answer to their specific efforts to serve those populations. Other examples of identity symbols include gender symbols, the transgender pride flag, and iconography associated with the Black Lives Matter movement.
15. Centers should consider including external community members who are BIPOC, LGBTQ+, people with disabilities, and people in larger bodies on a governing or community advisory board or for training and consulting. These people should be compensated appropriately for their expertise and services provided.
16. Treatment centers should allow staff the option to identify as BIPOC, LGBTQ+, people with disabilities, and people in larger bodies in anonymous employee engagement or climate surveys. Surveys should include question(s) uniquely relevant to these populations.
17. Client satisfaction surveys should allow patients the option to identify as BIPOC, LGBTQ+, people with disabilities, and people in larger bodies. Surveys should include question(s) uniquely relevant to these populations.

ADDITIONAL RESOURCES

ANAD WEBINARS

[“The Weight of Stigma in the Treatment of Eating Disorders”](#) by Lisa Erlanger, MD, Juith Matz, LCSW, and Aaron Flores, RDN

[“A Guide to the Guys: Treating Men with Eating Disorders”](#) by Brad E. R. Smith, MD

[“Gender-Inclusive Residential Treatment: Breaking the Treatment Binary”](#) by Emmy Johnson, MSW, LCSWA

[“Finding Hope in Telling Our Stories: Understanding the Intersection of Discrimination and Shame in the Treatment of Eating Disorders in People of Color and LGBTQ+ Communities”](#) by Norman Kim, PhD

[“LGBTQ+ Identity & Eating Disorder Recovery”](#) by Julia Sadusky, PsyD

BOOKS

Not All Black Girls Know How to Eat by Stephanie Covington Armstrong

The Incredible Jake Parker by Angelo Thomas

The Body is Not an Apology by Sonya Renee Taylor

Fearing the Black by Body Sabrina Strings

CONNECT WITH ANAD

ANAD (National Association of Anorexia Nervosa and Associated Disorders) provides free, peer support services to anyone struggling with an eating disorder. Learn more at anad.org and connect with us at these links:

- Facebook: facebook.com/anadhelp
- Twitter: twitter.com/anadhelp
- Instagram: instagram.com/anadhelp
- YouTube: youtube.com/anadvideos
- LinkedIn: linkedin.com/company/1965458