Race and Eating Disorders

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For many years the prevalence of eating disorders has been culturally viewed (very incorrectly) as a disease that affects white, middleclass, girls. Despite the fact that our understanding of the victims of disordered eating patterns has increased beyond the stereotypical boundaries and those who suffer has been more widely defined- society still hasn't come to change its’ norms. Still today eating disorders like bulimia and anorexia still conjure images of affluent white teenage girls living in a skeletal frame. And most studies of these disorders have focused on white patients. For years this practice of believing that anorexia and bulimia didn’t happen to black, Asian or Hispanic women, that they were somehow ‘immune’ was commonly accepted. I conducted a series of interviews with women who have both personally and professionally interacted with sufferers of disordered eating patterns, most specifically Anorexia Nervosa and Bulimia Nervosa. These interviews were centered on the issue of race and whether one’s race actually affects patterns of disordered eating. The results from my conversations however didn’t tie up many loose ends, instead new questions were raised. But one common thread prevailed throughout the majority of discussion-the fact that society is wrong, people of all races and nationalities are equally affected by the disordered eating patterns and the schisms they bring into modern society and into the lives and relationships of every victim. Throughout the interview process several underlying factors were presented on why it is that black women seem, to the ill-informed eye, more resistant to the effects of anorexia and bulimia. Factors including socio-economic levels,
availability of knowledge and education in the matter, health care and insurance issues, along with the culture and the social stigma disordered eating patterns yield - all help to hide racial prevalence.

Health care and the concerns surrounding accessibility and provision have grown into a national concern as of late. And not only does this issue effect working class American families and their ability to provide care for themselves and most importantly America’s children, but health care issues have extremely influenced those struggling with eating disorders. Mary Gee, of the Eating Disorders Coalition for Research as well as a Policy & Action Board Member for the Eating Disorders Resource Center, tackled this issue head-on. She discussed with me some of the basics of the US health care system, “On a systemic level, the US healthcare system is not set up to be able to effectively treat EDs (i.e. lack of national parity law, affordability of health insurance, limits on mental health benefits, etc.). Some can afford to take out second mortgages/independently finance treatment (which can easily run into the thousands of dollars for inpatient/residential), but even this can deplete a family’s finances since Eating Disorders are not always successfully treated on a first try. It is also important to look at the demography of who can afford health care coverage and has access to it.” Doctor Noelle Kerr-Price is an eating disorders treatment specialist and staff psychologist at Remuda Ranch Programs for Anorexia and Bulimia, and in discussion with her she helped to shed even greater light on this pricey issue, “One thing to keep in mind that we don’t even really know the full extent of how many people have eating disorders because many cases aren't reported out of shame or people are misdiagnosed -- if they are diagnosed at all. And those are the fortunate ones with access to health care and other recovery resources. Current rates for intensive in-patient centers can
cost as much as $10,000 a week. “And with many insurance companies not covering the cost of treatment for the majority of their members, access to treatment becomes the biggest issue on why we, in America, see more whites than blacks treated for both anorexia and/or bulimia.

Nicole Brown, MS, RD, LD, HFI a nutrition consultant, registered dietitian, and health fitness instructor based in Springfield, VA, shared the same thoughts with me when she expressed, “My gut feeling is its access to health care.” Jessica Wegener, RD is a colleague of Dr. Kerr-Price and a dietician at Remuda Ranch whom throughout her career has worked with over one thousand patients with eating disorders and specializes in Eating Disorder treatment, will go on to discuss the money issue as well. She has also linked economics and the availability of health care to those races that seek treatment. Jessica has noticed that her more ethnically diverse, as well as her lower-class patients, normally are more prevalently her bulimic patients. My conversations with Kristin Fabbri, MA the MEDA Director of Education and Outreach, not only backed up the assertions of many others, but she also brought a new idea into the health care/race factor. Fabbri discussed how, “Women of color who do have eating disorders may be reluctant to seek treatment for several reasons. They may be uncomfortable seeking treatment due to the fact that many mental health treatment professionals are white, and may not be able to understand the client's culture or speak their language. Women of color who have lower incomes may be hesitant to seek treatment, due to the high cost of treatment. Some women's health insurance may not cover treatment for eating disorders.” Thus, all the discussion over health care and economics with the disordered eating community and supporters seems to back up the idea that it’s not a racial white diagnosis, instead black women are just as effected by these eating patterns, it’s just that the ability and the monetary funds to
seek treatment inhibit black women from entering published statistics about anorexia and bulimia as often as their white sisters.

Access to health care due to economic levels seem to support the idea that black women suffer from eating disorders just as prevalently as white women do, then why does societal norms still not show this data? Is it due to culture and the stigmas of what is socially acceptable within the black versus white communities? Constance Smith, of the Virginia Department of Health, confronted the culturally-accepted beauty ideal within the black community, “In listening to my staff and working with clients who are African American, the standard image of a beautiful women is one who is heavier than the standard of a beautiful women for a white person. In my opinion, this image leads to less tendency in the African American population for an eating disorder from bulimia and anorexia but a higher incidence of eating disorders that leads to obesity (and not just for women).” However, to many within the field it appears that this belief is changing. For example, Deb Burgard PhD., Clinical Psychologist & Eating Disorders Specialist, completely supports that fact that black and white women are equally prone to disordered eating patterns- it’s just that black women’s symptoms are under diagnosed. Burgard goes on to assert the following, “People who are upwardly mobile and trying to assume power within the dominant culture are most likely to be subjected to its norms. So upwardly mobile people of any culture or ethnic background are supposed to look as Norwegian as possible. Hence, people in their attempts to be thin, and wealthy people and celebrities are both trying harder to look like the dominant beauty norms, and people of other ethnic backgrounds who look like the norms are less likely to be discriminated against.” Furthermore Susan Schulherr, the author of Eating Disorders for Dummies, backed up Burgard’s
claims with her input to me that, “Most of what I've come across emphasizes differences in body image and valuation of curves vs. thinness in white and non–white cultures. Same explanation for the rise of eating disorders among minority women who are more engaged with the majority culture.” Therefore, it appears that as black women have taken on the values and beliefs of the Western culture to which they have assimilated may be more likely to have negative perceptions of their bodies, and engage in unhealthy weight control behaviors. Fabbri entered into this conversation about the correlation between culture, race, and disordered eating patterns when she expressed the idea that, “Women of color can be even more vulnerable to low self esteem due to prejudice and discrimination they may experience.” This dominant versus minority culture debacle came up time and time again throughout my questioning the racial divide of disordered eating. Melanie Berde, RD and Nutritionist at the University of Virginia, expressed her opinion on this factor as well, “Certainly culture affects everyone, but in my opinion, cultural differences from the dominant culture add unique stressors for many people. In my experience, these students most typically come in on their own and their families are not initially aware of or openly discussing their struggle.” But what does this mean? Why is it that the beauty norms of one culture, no matter how outrageous they might be, can so negatively influence the perceptions in which minority cultures view themselves?

However, even with the mass of experts believing that disordered eating patterns don’t sit on racial sides—that everyone is effected equally and that it’s just the many factors that inhibit black women for being recognized as victims as often as their white peers; there are still many out there who find factors for why the issue doesn’t lie in reported cases. That in all
reality black women truly don’t deal, less suffer from these diseases like white women do.

Some believe that the black culture has more protective factors such as a better body ideal, less genetic vulnerability, etc. In the end, we must always keep in mind that we don’t really know the full extent of how many people have eating disorders because many cases aren’t reported and/or many people are misdiagnosed. It’s very clear that ethnic minority groups do develop eating disorders, perhaps not at the same rates as white women, we don’t know that fully, but they do exist. It’s very important that we understand what the problems are for those groups.

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