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Let's Talk About Culturally-Sensitive Eating Disorder Care:

Supporting the Healing of Black, Indigenous, and Racialized Clients

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> *"The folks who contributed to and created this resource are folks who look like us. We need to shift the language and the narrative when it comes to eating disorders. It's not just a 'white women thing'; it's not just one race that experiences them."*
>
> **– Francesca**

We are grateful to the consultants whose lived-experience, clinical, and research insights shaped the development of this resource. The quotes that appear throughout come from some of the rich and informative conversations that we had the opportunity to engage in with this group of individuals. We appreciate the permission they granted us to include these quotes. You will find a list of the individuals with whom we consulted and their biographies at https://nedic.ca/bipoc.

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What this resource is — and isn’t

Eating disorders (EDs) are highly complex mental health conditions – they can even mystify seasoned clinicians and it is no wonder then that many healthcare providers find it extremely challenging to address them effectively.

Many of us who are healthcare providers received minimal exposure to EDs in our educational and practical training programs. Similarly, many of us received little education about racism and how it influences people’s health risks and outcomes, and scant training in cultural humility and how to provide culturally-sensitive care to Black people, Indigenous people, and People of Colour (BIPOC). As a result, there is a significant gap in our healthcare system. The needs of BIPOC community members with EDs – a sizeable proportion of the estimated 4.6% of people in Canada who at any given time are living with an ED (Galmiche et al., 2019) – are not being met.

This resource is not designed to inform you about the different types of EDs and their diagnostic criteria. It is not a guide to any of the treatment modalities that have been identified as evidence-based. Information about the diagnoses, therapy models, and so on is widely available. You can easily obtain it from many places, including www.nedic.ca.

What is *not* widely available is literature about the intersection of EDs, race, ethnicity, culture, and trauma. Guidelines for providing culturally-sensitive care to BIPOC individuals with EDs are even scarcer. The intent of this resource is to serve as a starting point from which healthcare providers can develop their understanding of EDs among BIPOC community members and of practices they can adopt to support the healing of BIPOC clients who are struggling with an ED.

Misconceptions and myths

What an eating disorder "looks like"

EDs and disordered eating (DE) do not "look" a certain way. They are as diverse as those they affect – people of all ages, genders, body sizes, socioeconomic classes, racial backgrounds, ethnicities, and abilities.

Historically, it was believed that EDs only affect white, middle or upper class, cisgender girls and young women, and that they manifest as a desire to be thin that drives restrictive eating behaviours and results in emaciation. However, many people's understanding of EDs is derived from narratives from an era in which only thin, white, wealthy girls and young women presented for treatment – because they were the ones who were able to access it.

The reality in North America is that EDs affect BIPOC community members at rates comparable to white people (Goode et al., 2020; Marques et al., 2011; Streigel-Moore et al., 2011). Moreover, BIPOC individuals may be more likely to experience difficulties with certain DE behaviours.

It is also critical to keep in mind that people engage in DE behaviours for reasons other than to match the dominant culture's thin body ideal; for example, some individuals restrict, purge, or exercise intensely to regulate emotions (Kinnear, 2021). A drive for thinness, and weight and shape concerns more generally, may be less prominent symptoms among BIPOC individuals compared to white individuals (Mikhail & Klump, 2021).

> "A lot of folks who experience eating disorders do not get recognized or treated because it doesn't fit the criteria and knowledge out there. Our ability to help folks is limited to, or depends on, how an ED is defined." – **Filsan**

It is crucial to recognize that a person who is not at a low weight or who has not experienced drastic weight loss can have a restrictive ED. This is an especially important consideration for BIPOC populations. Research suggests that, compared to white people, lower weights are less prevalent among some populations and certain groups may present for treatment at higher weights (Lin et al., 2022). Relatedly, a person who has achieved weight restoration can still be struggling with disordered thoughts and behaviours and need support.

The biopsychosocial model is useful for understanding how and why EDs and DE develop as it centres the undeniable connection between mind, body, and the environment. It considers individual-level and socioenvironmental factors, and emphasizes the importance of understanding health and illness in their full contexts.

It has been proposed that individuals who develop EDs were born with particular biological traits, inherited through genes – for example, a tendency to be anxious or perfectionistic, or brain circuitry that is especially sensitive to food cues (Frank, 2016). In certain environmental conditions, which could be low food availability or exposure to violence to name a couple, these traits become relevant (Frank, 2016). Biology influences how one perceives and responds to their environment and life experiences.

People are a tapestry; there are many overlapping issues that can make it difficult to directly address behavioural symptoms. For instance, the racial trauma experienced by Black people in North America is intertwined with a history of slavery, or in other words, of bodies used as labour. Misogynoir – how race is gendered for Black women, gender-diverse people, and queer people – plays into the demand for bodies to look a certain way, which can give rise to DE and EDs. Books like *The Body is not an Apology* (Sonya Renee Taylor), *Fearing the Black Body* (Sabrina Strings), and *Belly of the Beast* (Da'Shaun L. Harrison) explore these relationships in depth.

A developing scientific field, epigenetics, is showing that environmental factors can leave chemical marks on genes that affect the extent to which they are expressed, and these marks can be passed down to subsequent generations (Jiang et al., 2019). Given the deprivation, oppression, and violence to which BIPOC populations have been subjected throughout history, epigenetics must be considered as a factor in the experiences of EDs among BIPOC individuals.

What “health” and “recovery” mean to us

The World Health Organization (2020) defines **health** as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In recognizing mental health as an essential component of health, it provides a definition of mental health as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community” (WHO, 2022).

The pervasiveness of Western diet and wellness culture, however, has skewed the way in which many of us understand health. Many of us have been led in our upbringing and other early life experiences and in our healthcare training to believe that body weight is a reflection of one’s health, that it is readily controllable, and that fatness is an illness that must be treated. With these beliefs, we may endorse weight control as a means to promote health, and we may find it hard to recognize that the pursuit of weight loss can severely impact mental well-being and that a person who has achieved a weight loss goal or whose weight is within the “healthy” or “normal” range may in fact be struggling with DE thoughts and behaviours.

> “I wish they [healthcare providers] focused on holistic health; not from a fatphobic lens, but from a health- and self-focused lens, which to me means keeping up your physical and emotional health because this helps you be the human you want to be. When I think of holistic health, it’s very much focused on the person and the idea that this person – as they are – is inherently valuable. As this valuable human is moving through the world, how can we make sure that they’re staying here as long as possible, and having a good life while they’re staying here? Because they deserve that.” – **Grace**

> “When I was in treatment…when we did meal plans…they were giving us lists of food that was all very Western and Eurocentric and when the nutritionist would tell me ‘oh, you can add some variety to your dinner’, I was kind of like, ‘I’ve been eating rice and some meat and some vegetables for my whole life, I don’t really know how to add that variety.’” – **Melissa**

Our early life influences and health care training may also have led to the development of specific Western ideas about “healthy” foods and eating patterns. Consequently, we may not readily appreciate that the food choices and eating patterns of BIPOC clients are consistent with their cultural background and that they are not “unhealthy” or “disordered”, but in fact nourishing.

The definition of **recovery** is contested among professionals in the ED field; while there is broad agreement that it entails the restoration of physical health and a significant reduction or remission of behavioural symptoms, the various other aspects of well-being are inconsistently included (Bachner-Melman et al., 2018; de Vos et al., 2017).

Within a culturally-sensitive model of health, health could be defined as a life lived in balance, or with meaningful engagement, with the various systems of which an individual is a part (Knibb-Lamouche, 2012). These systems include their environment, community, and family. Within this model, the way we define recovery therefore must be holistic and flexible and take into account not just the DE symptoms, but the individual and how in-balance or purposefully engaged they feel they are with the systems in which they are situated (Knibb-Lamouche, 2012). Implicit in this definition is the importance of letting clients tell us what recovery means to them and respecting their words.

> "I healed in stages. First I healed my mind with psychologists. Then spiritually. The stage that I am in now in my healing journey, it's my physical body, and it's not about exercising, not about being skinny; it's just being healthy, because I have grandchildren I want to grow old with. I joke how I want to be the oldest person who ever lived so I better look after this vessel with nutrition, feed myself properly." – **Lalita**

> "A lot of times when we've 'recovered', it might feel like we've arrived somewhere and nothing problematic will come up for us. You don't arrive – it's a journey. You learn tools, how to respond. You know your red flags and identify where to go for help." – **Cristel**

> "I remember when I was advocating for myself and getting into treating myself, it was that voice in my head…that little resilient voice…I think that inherently was like a life-giving voice. The ED for me, it never died. I think it became less impactful. It became less controlling, because I have been in active recovery for more than a year, and I still hear that voice. But that voice is just not as loud. And I have a bigger voice." – **Samiha**

Structural barriers to care

This resource challenges the problematizing of other cultures' beliefs and practices that often leads to perceptions of difficulties experienced by their members as faults of their culture, as opposed to products of structural conditions borne out of capitalism, colonialism, and wider systems of supremacy. The consultants who shared their insights and stories for the purpose of developing this resource gave dozens of examples of products of the intersection of the various forms of oppression to which BIPOC communities have been and continue to be subjected:

- the caste system and shadeism
- the demonization of "tiger moms", but also feelings of intense pressure among women to adopt the "tiger" approach to parenting as a means of ensuring their children achieve economic success
- bodies of people of certain communities being tied to class and labour as a result of slavery and indentured servitude
- the intersection of religion, power, and guilt
- the lack of representative role-models of colour in media and in positions of influence in North America
- the abandonment among community members of their cultural practices and foods, and the adoption of hair styles, clothing, and ways of expressing gender in an effort to appeal to whiteness

Poor mental health literacy in BIPOC individuals may be attributable, at least in part, to marginalization and oppression that has limited their access to information and resources. If we – healthcare providers – frame it as a result of structural barriers, we can better understand why people of colour may be less likely to seek help when they are experiencing mental health distress, and the difficulties that may present when locating their concerns relationally in their lives.

These structural conditions can contribute to the lack of trust BIPOC communities might have in Western health care. For those who decide to access care, transgressions committed by individual healthcare practitioners (e.g., comments that stereotype members of a cultural group) and certain types of institutional practices (e.g., reliance on the Body Mass Index, which is rooted in anti-Blackness and anti-fatness, as a measurement of health; Strings, 2019) can hinder clients' treatment engagement and healing. This can lead to many accessing care later in life, often at higher levels of severity as an ED/DE has festered.

It is important to communicate clearly about the realities of treatment options – the limited availability of publicly-funded services and the potential gaps around cultural sensitivity within care models – to help manage expectations, while recognizing that this information will likely be demoralizing to hear. Even in private settings, there is scarcity; few providers who see people with EDs, even fewer who may identify as BIPOC, on top of the cost of it all.

Finally, EDs rarely occur in isolation – co-occurring issues can compound accessing, receiving, and responding to care. In many newcomer families, seeking information and care related to a potential ED may not seem like a priority compared to learning a new language, adapting to a new culture, and finding community. Correlations between race and socioeconomic status mean that BIPOC communities can be more likely to experience food scarcity, which can happen from a combination of living in a food desert or food swamp, not having money to purchase food, and not having time to prepare meals as they bounce between precarious jobs. Overlapping mental health challenges can result, such as depression, anxiety, and substance use – the latter presenting a further barrier as co-occurring substance use is often an exclusion criterion for people accessing care for their ED, despite the biopsychosocial relationship between the two issues. For Indigenous peoples, the trauma of residential schools, continued family and cultural separation, and inequitable service access on reserves has sown the conditions for silence.

Healing philosophies and approaches

Trauma-sensitive care

For people who have experienced trauma, the immediate threats around them or in their environment can push getting support for an ED down their hierarchy of needs, which can be a real barrier to care. As an example, consider an individual who does not know whether it is safe for them to return home; discussion about a meal plan for restoring their nutrition status might not be one of their priorities. For some affected people, their DE behaviours can be conceptualized as coping mechanisms that developed in response to trauma.

It can be especially difficult to tease apart the relationship between DE behaviours and health when a client has a history of being discriminated against due to their body size. Relatedly, employment can be tied to health status – a consultant shared that in their country of origin, it is standard practice to undergo a health assessment as part of the hiring process and they were used to being measured, weighed, and judged by healthcare professionals as they were trying to get a job, which played into a fear of being labelled a person with an ED because of employers' perceptions.

> "Someone's size can make them feel like they don't belong in our society because our society doesn't make space for them. Then they feel like 'I can't live my life if I don't lose weight'. Their poor relationship with food and their body may have started when they were a child or teenager. If we were able to mitigate body and food shame at a young age, they wouldn't, at 60 years old, be struggling to get acceptance, and to be listened to at their doctor's office, and to be respected at work." – **Cristel**

CONSIDER THIS: food and trauma

Eating (or not eating) can become a way of coping with a stressful situation or unstable environment; food intake may present to a person a means of controlling something when they feel out of control, or gaining a sense of comfort. It is important to differentiate between "emotional eating" (or "comfort eating") and "binge eating" with a client. The former could be normalized as behaviour that many of us regularly engage in as a part of our day-to-day lives, given the sensory and emotional comfort that eating naturally provides, and the rich food histories of many cultures – communal eating is a common value. The latter is characterized by a sense of loss of control, and a person may experience immediate comfort followed by emotions like guilt and shame.

These coping mechanisms can be present in people's relationships and familial dynamics – such as a person observing this behaviour in their parents or the association that can form between certain foods and specific memories of past experiences. These connections are relevant to both nutrition and psychological professionals as clients might benefit from strategies in both realms as they work to heal.

On the following pages are trauma-sensitive principles for providing ED care, developed from the ground up by consulting with BIPOC community members who have lived and/or professional experience with EDs. Philosophically, this is what being trauma-sensitive means to us: "Your symptoms are not your fault. It's not a personal or moral failing. We can understand what's happening to you. It makes sense – *and* you can do something. We can do something together to help you feel, think, and act differently. This de-pathologizing is so valuable – taking the blame away – that this isn't a failure or you being 'out of control'. For BIPOC, there's this stigmatization that happens with mental health particularly, that this is because there's something innately wrong with you/me/us. In a way, that's what society has told you – 'you don't fit' – that gets extended in EDs. You do fit, it's *not* your fault, we can work together to help." (Elizabeth)

PRINCIPLE

It's on the practitioner to create an initial environment that enhances safety to set the conditions for disclosure.

Rationale

Many BIPOC people who have experienced trauma are used to being "handled rough" – being received with suspicion, doubt, or labelled as a "difficult client". Observing avoidance, shame, guilt, and suspicion from them are normal responses given this mistreatment, which can be compounded by the feeling of not "fitting the mold" of someone who has an ED.

Experiencing lateral discrimination can be painful – being told what or who you are by other people can lead to a loss of a sense of self. Some can experience this *within a community* as well, such as colourism being used as a determining factor in who gets to belong as a member of a community.

Principle in practice

Making historical or racial trauma a conversation point in treatment can be valuable as an act of healing in and of itself. Ask: "What has happened to you? Can we talk about this?" If your practice asks about social identity (e.g., gender, race) on an intake form, give people an opportunity to honour that intersection in conversation as a part of care planning.

PRINCIPLE

Understand that EDs can have intergenerational impacts.

Rationale

If you're meeting with a client who has been obeying their family members despite experiencing distress, pause if you're thinking "you don't have to take that from them, you should speak up for yourself". Speaking up in that environment could cause much more distress. In many cultures, the opinions of extended families hold additional importance – aunts and uncles may be seen as second mothers and fathers, and grandparents may have the "final say".

Principle in practice

Explore what boundary setting could look like while centering a client's sense of respect or fairness. Ask: "What would a positive outcome look like in this situation? Does this feel fair to you? Does this feel fair to the other person?" Normalize that we might not be able to change the mindset of a family member, but that we could still create a situation that protects ourselves – and potentially other people (e.g., nieces, nephews, children) in the family environment – a bit more than before.

Be careful about labels being put onto a client, such as "your parents sound abusive" (from you, a group member, an adjacent provider, etc.). There could be culturally normative behaviours or systemic conditions at play, and a client might retreat if they believe that their culture is being pathologized. Instead, explore how they feel about their family members and discern what type of relationship they want to have. There might be a grieving of a relationship they *wished* they had while they reconcile with their present reality.

When considering bringing family members into a client's session, cultural beliefs about mental health ("my parents don't think there's anything wrong with me") can intersect with practical concerns like a language barrier that can make engagement tough. Open up a space for collaborative problem solving: "How can we help you if you're struggling with your family and they don't understand?"

> "My parents' response to crying was, 'no tears, no crying'. I couldn't talk to them about certain things when I was a little girl. But I could forgive them for all of that after learning about residential schools. It stripped them of their own parenting because they didn't have parents at the time [when they were young], going through all that abuse, seeing it, and being part of it, so it's understandable. I feel like I had to heal for my children and my grandchildren, so I don't talk to them like how I was raised." – **Lalita**

PRINCIPLE

Label structural issues as structural issues.

Rationale

Many practitioners might share a reflection like “we live in a body-focused world; you can only control what you do, not your environment” in an attempt to appeal to a client’s logical mind. However, without naming those environmental factors – the institutions and systems of power that have created the sociocultural conditions for EDs to develop – we run the risk of putting more responsibility on the person with the ED.

Principle in practice

Naming potential environmental factors, asking your client how they see the influences of these factors in their life, and discussing who is responsible for what can be freeing for a client and contribute to disrupting internalized narratives of shame and self-blame.

Acknowledge for clients who have been deprived of access to cultural foods, which may have occurred for reasons including geographical displacement, migration, or poverty, that healing from their ED/DE may be particularly complicated. For those who lacked opportunities to develop an understanding of their culture’s foodways, (re)establishing a positive relationship with food may be more difficult compared to clients who have not experienced this type of deprivation.

> “I find that a lot of clinical spaces avoid conversations about fatphobia and how it’s connected with white supremacy, colonialism, and capitalism. It’s empowering for communities of colour to know that [the dominant culture’s] way of controlling bodies, wanting them to be thin, and whitewashing food is a colonial project. Controlling food intake becomes a way for people to gain control in their lives. For me, controlling food wasn’t just to be thin; it was a way to have control in my life. For me, it’s liberating to have this idea that this ideal that I want to reach is completely fabricated. As someone who seeks to be an advocate in my community and seeks to tear down oppressive systems, it’s comforting to know that I can resist just by pursuing my authentic self. Understanding that this [cultural appearance] ideal is very much based on capitalist greed and was formed through anti-Blackness to distinguish white folks from people of colour, it’s sort of like ‘this was never meant for me’ and there’s this beauty in resisting.” – **Grace**

PRINCIPLE

Understand and communicate about risk appropriately.

Rationale

When we learn information like “[health condition] is more prevalent among [a population]”, it’s important to put it into context. For example, there isn’t anything *inherently* about gender or sexual orientation that puts a person who identifies as 2SLGBTQIA+ at five times the risk of having an ED compared to a cisgender, heterosexual person (Diemer et al., 2015; Nagata et al., 2020).

Principle in practice

Explore how a person might be treated differently because of their social identity (e.g., race, gender, sexual orientation). Situate their DE behaviours in that context rather than within individual-level decisions, and consider how these behaviours have helped them cope with the resulting stress.

Explore ways in which their identity has been protective and has fostered positive mental health.

PRINCIPLE

Facilitate exploration of what is possible.

Rationale

Clients from BIPOC communities who have faced barriers to accessing support and resources to facilitate recovery might be especially prone to developing a feeling of being stuck in their ED or a belief that they will never be able to get better.

Principle in practice

Share a perspective that when someone makes a disparaging comment, it might not be about you, but about the commenter themselves and their own struggles. Explore with a client: “How are you going to respond when someone says a comment to you?”, noting that answering directly is only one form of responding. You can discuss how to prepare for situations that might arise by finding language that honours how they’re feeling (e.g., “I know this uncle is going to comment about the size of my hips, so how am I going to respond?”) or through setting expectations about what would be a positive outcome from this specific situation. Creating safety might look like surviving some interactions with a delay tactic, while directly responding to others.

Model that in many cultures, our bodies changing as we age is seen as a gift – not many get to live to old age and people seek out the advice of elders because of all the life they have lived.

Normalize that support systems can look different for every person. Involving family members into treatment can be difficult for multiple reasons and what is more important is having a web around the person affected.

Use a harm reduction model: “There’s this idea that we’re looking at medical acuity and life interference and we’re going to tell you what you need to do to stay alive. If you don’t do what we’re telling you to do, you’re out – come back when you’re ready. I think that leaves out a huge opportunity for helping people. Try ‘where can we meet you to help support you in your recovery?’ instead of ‘there’s only one way to get better.’” (Elizabeth)

Cultural humility — what it is and how we can practice it

In this resource, we have decided to use the term *cultural humility* instead of cultural competency and will be defining it using a series of principles as seen in the table below. We believe the very foundations of cultural humility – **not making assumptions about people based on their culture and instead, getting curious about each person and their context as a learner, not an expert** – is useful for not just every practitioner to use with every client, including white clients, but every human being. There is value in self-reflection to figure out how your client relationship fits within wider positions of privilege, acknowledging those realities outwardly, and actively navigating together how that might come through in whatever setting or institution you are practicing.

> “Even for professionals who are BIPOC or come from the same cultural background as their client, they might also have internalized racism and cultural assumptions that they have to work through in order to get to a realization that not everyone’s experience is the same and that ‘this is similar to me in these ways and different in those ways.’” – **Alexandra**

Taking this stance is important given the reality that many of the tools that currently exist for assessing and diagnosing EDs were developed and validated using data from study populations largely comprised of white women, and therefore potentially limited in their effectiveness in detecting eating-related distress in BIPOC people. ED assessments with BIPOC clients often lack exploration of the influence of their cultural background and experiences of racism and trauma on their struggles with food and body. For example, while it is widely recognized that the thin body ideal is a contributing factor in the development and maintenance of EDs, what is often overlooked is that it is a white, Eurocentric ideal.

Similarly, treatment modalities that have been established as evidence-based and that are in wide use are grounded in evidence from research in which BIPOC identities were underrepresented (Egbert et al., 2022). Of note, within these treatment approaches there are recommendations that conflict with some communities' cultural and religious practices.

CONSIDER THIS: religion and spirituality

Faith, religion, and spirituality have long played a role in mental health. Systemically, the connections between religion and power that gave rise to enduring colonial structures impact cultural beliefs about "health" and "well-being", including the role of food. Many scriptures contain food-based ceremonies and symbolism (e.g., "gluttony", "the forbidden fruit"). On an individual level, these beliefs can affect a person's mental health – as a positive, protective influence and as a barrier to care if reliance on a God's power to heal prevents them from seeking or receiving support.

The presence of fasting rituals in many religious and spiritual traditions can complicate ED/DE care, especially when weight- or body-related motivations blend with the religious connection. Clients may live in a household with these mixed narratives, which can lead to confusion as they try to reconcile their own relationship with family, body image, eating, and faith.

Consider inviting a client to reflect on what role, if any, spirituality can play in their healing. It might be helpful to talk about religion and spirituality as two separate constructs. These connections can be restorative by allowing clients to interact with a belief system that is larger than their own narratives around body image and eating, and can inform coping strategies (e.g., prayer as a mindful practice to reduce anxiety and set intentions). For many Indigenous peoples, the medicine wheel – being in balance with physical, mental, emotional, and spiritual health – is a framework that can be a guide towards healing. Make space to allow for a cross-examination of Western healthcare practices with these traditional knowledges as a means towards client self-determination.

PRINCIPLE

Be open-minded to: a) acknowledging that we've likely been trained in systems where supremacist and colonial structures have impacted what we think are "normative" and "non-normative" behaviours and; b) continuously unlearning and relearning as the bedrock of acceptance in our practice.

Principle in practice

Create a supervisory structure (clinical supervision, peer support, consultation meetings, etc.) wherein you feel comfortable questioning your foundational beliefs (e.g., "What is mental illness?") and checking in with any countertransference that arises (e.g., "Why did I say those things? Why was that my reaction? How can I give power back to my client?"). Develop strategies in supervision to help you acknowledge biases (e.g., presence of racism, "dominant" culture) when it's happening, both personally and outwardly with your client.

Recognize that feeling doubt and hesitancy as a professional can be a positive sign that you're being person-centred, as opposed to an indicator that you're failing because you aren't confident.

Keep a journal to document experiences from different cultures so you can build a repertoire of understanding; it can help with your own engagement and also be a tangible example to share with a client to promote buy-in and ease potential mistrust from prior experiences in the healthcare system. Learning doesn't only have to come from reading research articles or attending training sessions; it can involve talking to your neighbour or a friend.

PRINCIPLE

Work to understand power dynamics, and what it would mean to give power back to your client.

Principle in practice

During an initial appointment, inform clients of their rights (e.g., referral to another provider if they aren't seeing a fit with you) and talk openly about ways in which they can offer you feedback. Speak about your willingness to own your mistakes, not as a form of self-deprecation, but as a human who takes their responsibility as a healthcare provider seriously as you work together towards a person's goals.

Ensure that you're conceptualizing the ED in more ways than through a singular model (diagnosis, assessment, theory) by including the client in a discussion about how they see their ED's development. Hold the stance that you believe in their ability to heal themselves by stating that they have actually been trying to engage in that healing all along – highlighting their resiliency not pathology.

Model to clients that you understand that race and culture are not monoliths – that there are aspects of human experience that are similar across people and others that are very different. Even if you share a background, your experience is not their experience. State early on that you view them as the expert of their own experience, and share that if they don't feel that way, part of your work together could be allowing them to find their own voice as they build trust and self-belief.

The presence of "individual responsibility" messaging around healthcare outcomes can create the conditions for self-blame. Provide an antidote to that messaging by opening up a conversation about the systems and structures in place that can make someone feel a certain way and potentially resort to ED behaviours.

PRINCIPLE

Create space for conversations about race, culture, and identity by asking questions openly.

Principle in practice

In the assessment phase, explore the cultural origins of the person's relationship with food and the extent to which the individual (and their family) adhere to these norms (e.g., "What type of food do you typically eat? What does the meal environment look like? What are the traditions or rules that your household tends to live by?"). Sometimes we assume that because people are from a given country, they eat a certain food, when that might not be the case. When clients disclose a challenge with eating in passing ("Oh, I've been having trouble eating healthy lately"), make time to talk about it. It could look like checking in at the start/end of your appointment or actively making it a part of your agenda.

Explore what it would mean to honour their full selves – including culture, race, and other aspects of identity – through their own words and actions as they work towards getting love and support through the challenges they're dealing with.

"In Western culture, a slender physique is the standard of beauty, and there's pressure to be in sync with that. When you climb certain ladders, academically or in the workplace, the pressure to be acculturated is higher as opposed to when you're surrounded with your loved ones in your community. Sometimes there's pressure to change to be successful. I remember a Ghanian patient – she was very ambitious. She was being validated for being slender, not having the typical [shapely] physique. Her journey for healing was about coming to grips with who she was as an African woman, reconciling her values of who she is and what she carries versus conforming in order to achieve success." – **Consultant**

"There's a Twi concept, *sankofa* – 'one should remember the past to make positive progress in the future'. Being a Ghanian woman living in Canada, it's important to remember where I came from. I'm remembering that – with my mom – and trying to shift the narrative. My BED didn't come from nowhere; we saw things growing up and we silenced it. We're trying to change it, and that includes our relationship with food to create something positive in the future. Look at me as a whole. The ED could stem from something, not separate; it does contribute to some of the challenges I'm experiencing these days and why I'm seeking support." – **Francesca**

PRINCIPLE

Acknowledge dialectics (“both”/“and”/“yet”) and work to depathologize thoughts and behaviours.

Principle in practice

In individual relationships, emphasize that there are pros and cons that are going to be different for each person; try to hold space for a middle path instead of leaning into morality (“wrong”/”right”). This is especially important in situations where it might be difficult to change the person’s immediate environment (e.g., living with family, financial insecurity, minor without full legal autonomy). Offer skills or strategies to increase independence or distress tolerance if they find themselves in cultural situations that may exacerbate ED behaviours (e.g., religious fasting, fitting into cultural garb with restrictive sizes) while honouring potential wishes to respect the meaningfulness of those cultural traditions.

Sit with contradictions and explore whether there is a structural issue underlying them. For instance, many love to eat *and* feel guilty for eating too much. Helping to label where that guilt comes from – potentially from supremacist or misogynistic underpinnings – can be a step in rekindling the ability to listen and trust one’s body.

> “There was that conflicting messaging that I got – it really complicated my relationship with my body. On one hand, the older generation, my grandparents/great aunts were in larger bodies and to me, they seemed very healthy. Then in my household, with my nuclear family, the message was that being too big is bad and is going to cause problems and you want to be careful not to get to that size. Coming here to Canada and seeing thinness glorified – those conflicting messages definitely factored into my ED struggles. It became all-consuming in my mind because here, you’d go to a health facility and you’d hear people talk about the ‘obesity epidemic’ and you become scared and you make an effort in your daily routine do all of these things to not get to that size.” – **Filsan**

PRINCIPLE

Explore cultural knowledges that can be used to develop healing narratives.

Principle in practice

Invite clients to talk about cultural teachings that have been passed down to them that help them feel grounded or that increase their sense of connectedness to themselves, their values, and other people. “From an Afro-Indigenous perspective: some of the things I was taught was beauty is this integrated, holistic, interconnectedness between the self and the environment. Beauty is not the individual body, it’s how we flow and intersect with everything around us – there’s a de-emphasis on the body and an emphasis on how we walk in the world. [It’s] our ancestors, our roots, our ceremonies, our teachers.” (Elizabeth)

Familiarize yourself with different cultures’ foodways. Your ability to demonstrate knowledge of a significant aspect of clients’ daily life can go a long way in building rapport with them. “I had an Ethiopian client and they were like, ‘you know, we have this bread’, and I said, ‘oh, injera’, and she responded with excitement, ‘YEAH, you know it?’ Just having this miniscule understanding of their food and their culture made this person feel like I reached like a string and connected myself to that. Food is such a big part of culture, an emotional comfort thing, that when somebody understands your food and understands a little bit about it, they can feel this connection to you.” (Cristel)

PRINCIPLE

Consider that adapting structured therapy protocols based on clients' cultural beliefs or practices may be justifiable.

Principle in practice

Keep in mind that much of the evidence for ED treatments that are considered evidence-based was derived from white research participants; therefore, treatments delivered "by the book" may not work for BIPOC clients. "There's this idea [in family-based therapy] that siblings aren't necessarily supposed to take on the meal support role because it impacts the relationship between siblings because they turn into a caregiver. However, in a lot of South Asian families, older siblings are caregivers for a number of reasons – work dynamics, relationships, age differences – and allowing them to play a bit more of a role, I've found that a lot of my clients really benefited from that because it's easier to communicate their feelings and concerns [to their sibling] than it is with their parents." (Alicia)

PRINCIPLE

Recognize the cultural value(s) of food.

Principle in practice

When setting up any exploration around food, share that you appreciate that food is about more than just biological nourishment – it can be a source of connection, love, comfort; a focal point of ceremonies; a means of keeping up appearances; and more. Recognize that every culture has a distinct relationship with, and language for food, and allow for time during appointments to be spent trying to understand that relationship.

Pull information from your client before providing nutrition guidelines (e.g., the plate model) by asking questions like: "How has your culture and upbringing influenced your relationship with food?" and "How are foods traditionally prepared in your culture?" It's important for a client to not feel like they're doing something "wrong" by eating their cultural foods. If a client has a condition whose treatment calls for an increase or decrease in a specific nutrient, explore a variety of food options that honour their roots instead of only suggesting ones that might be top-of-mind for you (e.g., substituting white rice for wild rice when white rice is a staple of their culture).

Expand your understanding of cultural foods through experiential learning. For example, go to a market, pick something that doesn't have any English translations on it, and figure out how to make a meal out of it. Reflect on how it feels to be in a space where you don't understand the language.

> "It's important to talk about food shame from an intersectional perspective; not just 'you need to eat', but with an understanding of shame from multiple perspectives, including race and culture. [More specifically, this could involve breaking down] this idea that foods from certain communities aren't healthy and therefore you should not eat them. Thinking about immigrant communities, [it could also involve recognizing] xenophobia. A lot of people who are children of immigrants or immigrants themselves have experiences of going to school with their little lunch box, with their cultural food, and other people saying, 'ew, what's that?' I feel those experiences of racism can be deeply embedded in our relationships with food, as well as fatphobia, control, wanting to be thin, or using food to soothe." – **Grace**

Supporting someone without a support network

A strong support system is a key part of the ED/DE recovery process (Linville et al., 2012; Pisetsky et al., 2016). In addition to a treatment team that could consist of a dietitian, therapist, doctor, and other healthcare professionals, loved ones, especially family members, can play an important role in the recovery process for clients (Leonidas & Santos, 2014). However, the degree of support received from loved ones can differ greatly for a variety of reasons, including cultural differences, which should be considered for clients from BIPOC communities.

Food and family are important values in different cultures that can impact how comfortable a client feels about reaching out to loved ones for support. Stigmatization of EDs/DE is present among different cultures to varying degrees (Cheng et al., 2019; Rodgers et al., 2018; Simone et al., 2022), which may arise from a lack of knowledge and education about EDs/DEs (Acle et al., 2021; Melisse et al., 2020). Given the stigma around EDs/DE and the importance of food in cultural identity, clients from BIPOC communities may experience feelings of guilt, shame, fear, and discomfort around engaging in conversations with loved ones about their EDs/DE. In some cases, families and loved ones may have trouble understanding the client's disorder and therefore may be in denial or even blame the client for their condition.

Avoiding the assumption that affected individuals can engage in open conversations about their ED/DE with their families is crucial, as this may be a source of more distress for clients. If clients want to involve their loved ones in their care, healthcare professionals can help strengthen this support network by gauging their current level of knowledge and willingness to learn about EDs/DE. Often, families do not have malicious intents and their involvement as supporters can be improved by education and community resources and support that emphasize that EDs/DE are not abnormal or shameful.

It is important to note that a client's personal support network does not have to be comprised of their family. We encourage healthcare professionals to view "support network" as a neutral term that goes beyond preconceived notions of what a personal web of support should look like. For example, a client may be more comfortable confiding in friends or community members about their ED/DE. Moreover, a client's personal support network can be dynamic and may change over time to better align to the level and type of support they need throughout their recovery process. Given the fluidity of a support network, engage in dialogue with clients throughout treatment to help explore people who can be a part of their care and recovery. As an example, if the client expresses concern about involving their family, they can be redirected to think about other people in their life who may be useful. The client can consider people who may facilitate their healing process in different ways (e.g., someone might be good at listening in times of frustration and someone else might be good at consoling during times of sadness).

In some cases, clients may have difficulty identifying specific people in their lives that could take an active role in their recovery. However, other activities and resources can be helpful, such as volunteering, hobbies, community involvement, spirituality, and support groups. Therefore, by engaging with clients and learning about their interests, you can help expand clients' support systems in ways that work best for them.

Learning more and enhancing your practice

> “With regard to EDs, it’s ironic when acuity was high and assessment was thorough, how little attention was paid to cultural dynamics. How a culture views food is so important; when someone is restricting and they’re eventually going home, we’re not paying attention to that? It’s such a glaring oversight.” – **Consultant**

Understanding how the intersection of culture, race, ethnicity, and EDs affects individuals from BIPOC communities is an essential step in providing culturally-informed care. It is important to reflect on your own biases that may affect your interactions with diverse clients and how you may leverage the knowledge provided in this resource, your training, and other tools and resources to ensure that cultural dynamics are taken into consideration.

One way your practice can be geared toward intersectionality is by implementing an interdisciplinary approach with a culturally diverse team. Care teams comprised of practitioners trained in different types of therapies and that include members of the BIPOC communities can provide perspectives and treatment modalities that best fit a client’s needs. As a first step, investigating the current options that your practice offers to those of different cultural groups can help illuminate areas where your practice may be lacking and, in turn, pave the way for further improvements.

As a healthcare provider, you can enhance your practice by using your position of power productively through advocacy. Navigating the healthcare system and seeking help for an ED is daunting for most, but especially for members of BIPOC communities who face numerous systemic barriers to equitable care. Given the credibility associated with medical professions, healthcare professionals can influence policy and program changes, counter misinformation, and help educate the public. Advocacy can take form at many levels. For example, at the individual level, healthcare providers can request access to certain treatments and timely referrals to specialists. At the regional level, healthcare providers can advocate for funding of programs that may support certain communities. Overall, as a healthcare provider, you can help drive change that can dismantle barriers to adequate ED care for BIPOC communities.

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Links to other resources that you may find helpful are available at https://nedic.ca/culturally-sensitive-care

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