



Our Eating Disorders Blind Spot: Sex and Ethnic/Racial Disparities in Help-Seeking for Eating Disorders

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In the current issue of *Mayo Clinic Proceedings*, Coffino et al¹ present the results of the largest population-based study of *Diagnostic and Statistical Manual of Mental Disorders, Fifth Revision (DSM-5)* eating disorders to date. The researchers found discouragingly low rates of help-seeking behavior in adults with anorexia nervosa (AN) (34.5%), bulimia nervosa (62.6%), and binge eating disorder (BED) (49.0%). Because these authors defined help-seeking broadly, and included not only seeing a doctor, counselor, or therapist about eating or weight but also modalities such as chat rooms and support groups, it is unlikely that many individuals sought and received evidence-based treatment. Even more disheartening, the authors' findings bring to light sex and ethnic/racial disparities in help-seeking patterns. That is, depending on the eating disorder, men and ethnic/racial minorities were significantly less likely to seek help than were women and non-Hispanic white individuals. Given the relative inattention generally given to ethnic/racial minorities in the health care system, this is perhaps the most unsurprising finding of all.

In the interests of a more equitable reduction of suffering, as well as sound health care policy, we should consider a broad rethinking of the illness. Because many men and ethnic/racial minorities are not seeking help, it is in our collective interest to better identify all patients with eating disorders. Eating disorders have the highest rate of mortality and place some of the highest costs on the system of any psychiatric disorder.^{2,3} Untreated eating disorders can set in motion a cascade of complications, magnifying the severity and chronicity of these conditions and, by extension, the already imposing cost of care.

The findings of Coffino et al¹ that men and ethnic/racial minorities with certain eating disorders are less likely to seek care than the modest one- to two-thirds of all afflicted guarantee that these individuals will face some of the highest risks for complications, costly comorbidities, and poor outcomes in a patient population already at high risk for poor outcomes.

To explain this phenomenon, we seem to be experiencing the consequences of an illness narrative gone awry. A familiar paradigm has encouraged clinicians and the public to imagine that eating disorders are exclusive to frail, affluent girls of white race.⁴ As suggested by Coffino et al,¹ eating disorders affect a far more heterogeneous mix of sex, race, ethnicity, and weight status than is commonly understood. Depending on the eating disorder, men made up 8% to 27% of those with eating disorders in the survey, and 20% to 26% of those affected were nonwhite persons, a figure approaching proportionate representation for the US society as a whole. Given the portion of nonemaciated, nonwhite patients not seeking care, the conventional patient demographic profile as represented in popular culture has failed to resonate with a sizable portion of those with the illness, and this has considerable implications for treatment outcomes and illness burden.

Consistent with biases that eating disorders are a female condition, Coffino et al¹ determined reduced rates of help-seeking and treatment utilization for certain eating disorders in men. Although the authors found that men represent a considerable portion of those struggling with BED (27%), men were significantly less likely than women to seek help for their condition. The authors also discovered that compared with

women, men with AN were more likely to experience hospitalization for eating or weight-related concerns and that men with BED were more likely to receive emergency department services. It is possible that reduced help-seeking in men contributes to greater medical severity and subsequent need for acute medical and psychiatric care.

Moreover, the tendency to conflate eating disorders with low body weight might explain why Coffino et al¹ found that only one-third of individuals with BED, a condition associated with higher weight status, sought professional help. There is evidence that compared with underweight patients, higher-weight-status patients take longer to be identified and referred for treatment.⁵ This delay in care seems to stem from the misconception that eating disorders are associated with low weight, and it is likely to have negative consequences for the prognosis of higher-weight-status patients, including individuals with BED, bulimia nervosa, and atypical AN (ie, patients presenting with all the symptoms of AN except present at normal to above normal weight).

Although a renewed public health effort to broaden our imagined depiction of eating disorders is warranted, the responsibility falls on health care providers to identify and treat eating disorders across diverse patient populations. Because most eating disorders present in primary care, primary care providers are central to detecting these conditions, understanding their role in complex medical presentations, and directing patients to appropriate treatment. As it now stands, only half of patients with eating disorders are identified in primary care, and this generally occurs after the development of substantial medical complications, when precious opportunity for treatment success has been lost.^{6,7} Although primary care providers are likely to identify eating disorders in patients showing obvious signs of malnutrition and weight loss, many may not be attuned to the more subtle manifestations commonly seen in nonspecialty settings.

Physicians surely experience this blind spot thanks, in large part, to a research base

drawn almost exclusively from treatment-seeking individuals, participant samples that Coffino et al¹ show us are underrepresented by men and ethnic/racial minorities. In this dynamic, ethnic minorities are less likely to be asked by their doctor or mental health professional about eating disorder symptoms than are nonminority individuals with eating disorders, and this omission makes them less likely to receive a referral for treatment.⁸ In something of a self-perpetuating cycle, academic literature based on a narrow demographic sample of help-seeking patients has taught clinicians to look for more of the same, ignoring men and racial/ethnic minorities with eating disorders, further compounding these health care disparities.

In addition, clinician bias seems to be informed by conceptual errors concerning eating disorders reflected in outdated diagnostic guidelines pertaining to eating disorders and weight. In the DSM-IV,⁹ the diagnosis of AN formerly required a body mass index at or below 85% of expected for age and sex, a decidedly narrow understanding of the illness. Although the DSM-5¹⁰ has since eliminated this weight threshold, absolute low weight remains a fixed idea for most clinicians. Until we can broaden our understanding of these complex illnesses, accepting the possibility that patients with normal or even high body mass index may indeed fall below a healthy weight based on their own genetic requirements, eating disorders in patients of diverse weight will go unrecognized.

In focusing on a narrow subset of patients with eating disorders (ie, white, young females presenting with low weight), clinical screening is failing a sizable percentage of persons with these burdensome, costly, and often lethal illnesses. Coffino et al¹ remind us that men, ethnic/racial minorities, and higher-weight-status individuals compose a substantial portion of those with the illnesses and report the troubling finding that these persons are less likely to seek help. To correct this disparity, clinicians must begin to examine our biases

about eating disorders, as well as the factors that influence help-seeking in the first place. Until we accurately envision the illnesses in its full diversity in society, time-pressed clinicians will struggle to view an investment in universal screening for eating disorders as worthwhile. However, the pivotal findings of Coffino et al¹ call for a need to screen all adolescents and adults, regardless of sex, ethnicity, race, and weight status. Casting a wider net in screening for eating disorders will reduce expense and suffering and improve outcomes in those who have gone unrecognized for far too long.

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