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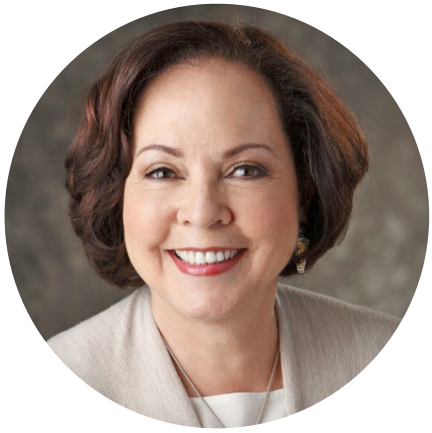
ASK THE EXPERT
with Dr. Kim

FEATURED EXPERT

An Interview with Carolyn Coker Ross MD, MPH, CEDS

Physician, International Speaker, & Consultant



Q. How do systemic inequities contribute to health disparities in access, quality, and outcomes eating disorder care for racially minoritized individuals?

A: Systemic inequities contribute to health disparities in eating disorder care for racially minoritized individuals through limited access to healthcare, cultural stigma and mistrust, underrepresentation in research, bias in diagnosis and treatment, socioeconomic factors, and a lack of culturally competent care. Many underrepresented minorities have issues such as lack of insurance, transportation issues, and language barriers, which makes it challenging to access care. Historical mistreatment and discrimination have led to stigma and mistrust in minoritized communities, resulting in reluctance to seek help. Research and treatment development studies most often focus on white, affluent populations, so there is little research that is relevant to racially minoritized communities. Because of lack of training in culturally competent care, clinicians may have implicit biases that can lead to misdiagnosis or treatment recommendations that are not effective for racially minoritized groups. Low socioeconomic status can exacerbate eating disorders and reduce likelihood that patients get treatment or treatment that is culturally incompetent can worsen outcomes.

Q: What specific challenges do BIPOC individuals with eating disorders face in terms of diagnosis and care?

A: BIPOC individuals with eating disorders can be underdiagnosed or misdiagnosed due to atypical symptom presentations and insufficient cultural understanding among healthcare providers. Stigma surrounding mental health issues within BIPOC communities compounds the difficulty in seeking support. Accessing care is complicated by socioeconomic disparities and limited specialized treatment options. Moreover, experiences of racism and discrimination contribute to trauma, exacerbating eating disorder development and hindering recovery efforts. It's important for providers to undergo cultural competence training to provide sensitive, trauma-informed care that acknowledges the unique challenges faced by BIPOC individuals. Addressing these barriers is important for ensuring that all patients, including BIPOC patients, get equitable care.

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Q: Can you elaborate on the significance of antiracist frameworks in addressing treatment disparities, as advocated in the presentation? How do these frameworks contribute to more equitable outcomes?

A: It's important to confront systemic racism within the healthcare system. By setting up antiracist frameworks, it is possible to de-center whiteness in care of eating disorders and prioritize culturally competent care. These frameworks can also include intersectional identities of race, gender, socioeconomic status with the purpose of addressing diverse needs. These frameworks can also be a factor in advocating for policy change and diversity of the healthcare workforce.

Q: What role does data-driven insights play in understanding and addressing the impact of systemic inequities on marginalized communities' access to quality care for eating disorders and substance use disorders?

A: Insights from data can help with the identification of disparities and barriers like gaps in insurance coverage and also clinical bias. Ongoing monitoring can help identify what's working and what's not, thereby improving outcomes. It can also be used as a tool of activism - giving proof that 1) eating disorder care is needed and important in BIPOC individuals; and 2) that there are specific interventions that we can prove work in this population.

Q: In what ways do harmful stereotypes contribute to barriers such as lower quality care and under diagnosis for individuals from marginalized communities, and how can these barriers be effectively dismantled to ensure more equitable treatment outcomes?

A: Harmful stereotypes just feed the prevailing narratives about marginalized communities. These biases can lead to more bias and differential treatment of patients - leading to delays in diagnosis and treatment. To combat these stereotypes, training of healthcare staff and clinicians, increasing diversity in providers and leadership can help improve understanding of BIPOC patients' needs. Policies must also be addressed – if a policy is not anti-racist, it is likely white-centered and therefore, biased and potentially harmful. Without stated anti-racist goals, mission and policies, it's easy for treatment facilities to fly "beneath the radar," convincing themselves that they are making changes without being held to account.

Q: What can white clinicians do to own their parts in dismantling current barriers and impacting change in the way of achieving equity?

A: Ongoing self-reflection is important. Secondly, they can advocate for diversity, equity, and inclusion within their facilities by promoting policies and practices that prioritize cultural competence, anti-racism, and equitable care delivery at all levels of the organization. Finally, white clinicians can engage in allyship by amplifying the voices of marginalized colleagues and patients, advocating for systemic changes that address structural barriers to care, and actively listening to and centering the experiences and needs of marginalized communities.