Community Based Strategies for Eating Disorders

Essential Information and Creative Strategies
When Treatment is Inaccessible

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Land Acknowledgement

Heritage University occupies its home on the traditional lands of the Yakama people. Heritage University, grounded in the vision of the two Yakama women founders, respects Indigenous peoples as traditional guardians of the lands and the enduring relationship that exists between Indigenous peoples and and their traditional territories. We offer gratitude for the land itself, for those who have stewarded it for generations, and for the opportunity to study, learn, work, and be in community on this land. We acknowledge that our University's history, like many others, is fundamentally tied to the first colonial developments in the Yakima Valley.

We would like to express our deep gratitude for the land on which we are on today, recognizing and honoring the Confederated Tribes of the Umatilla, including the Walla Walla, Cayuse, and Umatilla tribes.

Positioning Ourselves

The information, theories, and strategies presented are based on our own research, lived experience, and practice in the Yakima Valley

We honor and acknowledge both our own expertise and the ways in which we are in process as we move toward these community based strategies ourselves.

Who is in the room with us?

- Medical providers?
- Mental health providers?
- Dietitians?
- Case Managers?
- Students?
- Community members?
- Operations? Legislators? Directors?

Positioning Ourselves- Yakima area

Yakima County

- 43.8% Hispanic
- 47.3% White
- 1.8% American Indian/Alaskan Native
- 1.6% Asian American
- 1.3% Black

Yakima itself is considered “urban,” but Yakima County is rural

- Medically Underserved Area (MUA)- shortage of primary care resources
- Health Professional Shortage Area (HPSA)
- Nearly 22% of the Yakima area lives under the federal poverty level

When people are struggling, there are few resources, thus the need for community based strategies

Even when folks live in multiple intersecting privileged identities, there can be a lack of access to necessary services for eating disorders. The effect is magnified when folks occupy multiple marginalized identities.

Learning Objectives

- Participants will **review** diagnostic criteria for eating disorders and the significant health impacts of eating disorders.
- Participants will be able to **describe** how eating disorders and disordered eating impact marginalized communities.
- Participants will be able to **identify** at least three barriers to receiving eating disorder treatment in their community.
- Participants will be able to **describe** at least three intervention or treatment strategies they can utilize now to support clients or patients with eating disorders.

Case Study: Option 1

Carlos (he/him) is a 15 year old who is brought to his primary care provider due to his parents' concerns about weight loss, irritability, and stomachaches. He has told his parents that the stomachaches make it hard for him to eat dishes he has previously really enjoyed, and he normally eats very little or makes himself something different for family dinners. His parents also note that he doesn't eat foods he used to like at family gatherings. Carlos wants to join the cheer team this year, and identifies as one of the few LGBTQ+ students in his rural high school. Carlos' PCP notes that his heart rate is in the 50s, and his BP is slightly lower than usual, but otherwise he appears to be healthy. Carlos' parents are both farmworkers who work long shifts. Carlos has an older sister and two younger brothers.

Case Study: Option 2

OJ (they/he) is a 25 year old trans masculine nonbinary individual with a BMI of 35. He self identifies as on the fat spectrum, and has no significant physical health concerns outside of his BMI being classified as overweight. He was recently denied top surgery due to a BMI cut off of 35. There are no other surgeons within a 3 hour radius of where he lives, and the BMI requirement is required by both the surgeon and their insurance company. OJ has a history of over-exercising, and binge eating after long periods of restriction. While trying to follow his surgeons prescribed diet plan, OJ finds themselves turning to their eating disorder for “relief and comfort.”

Questions to start

Based on your current discipline, what concerns you?

What questions do you have?

What do you want to rule out?

Diagnostic Criteria

Eating and Feeding Disorder Diagnostic Criteria- Review

Anorexia Nervosa and *Atypical Anorexia Nervosa (AN, AAN)

- Restriction of energy intake leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health
- Intense fear of gaining weight, even though underweight
- Body image disturbance, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

Bulimia Nervosa (BN)

- Eating large amounts of food within a 2-hour period and sense of lack of control
- Recurring inappropriate compensatory behavior (vomiting, laxatives, exercise, diet pills)
- Binge eating and compensatory behaviors occur, on average, at least once a week for three months
- Self-evaluation is unduly influenced by body shape and weight

Binge Eating Disorder (BED)

- The most common eating disorder
- Recurring episodes of eating large amounts of food, more than most people would eat in similar circumstances in a short period of time
- Eating rapidly, eating beyond fullness and secret eating marked with distress around binges
- Sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)
- Binge episodes average at least once a week for three months

Eating and Feeding Disorder Diagnostic Criteria- Review

Avoidant Restrictive Food Intake Disorder (ARFID)

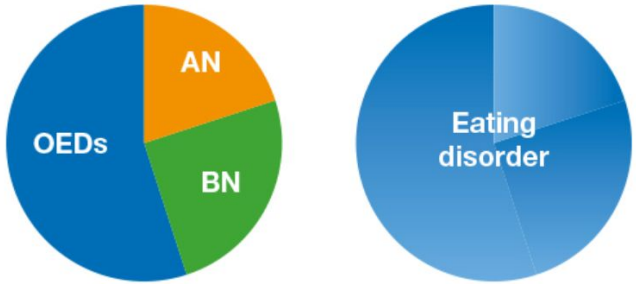
- An eating or feeding disturbance so pervasive that the person is unable to meet appropriate nutritional needs, resulting in one (or more) of the following: significant weight loss, nutritional deficiency, dependency on nutritional supplements, or interference in social functioning
- This problem with eating is not explained by a lack of food being available
- This is different from both anorexia nervosa and bulimia nervosa in that the problems with eating are in no way related to what the person believes about his/her size, weight, and/or shape
- This disturbance is not caused by a medical condition or another mental disorder

Other Specified Feeding and Eating Disorder (OSFED)

According to the *DSM-5*, the category of other specified feeding or eating disorder (OSFED) is applicable to individuals who are experiencing significant distress due to symptoms that are similar to disorders such as anorexia, bulimia, and binge-eating disorder, but who do not meet the full criteria for a diagnosis of one of these disorders.

*Severity modifiers are regarded by the ED community as harmful

Transdiagnostic Nature of Eating Disorders

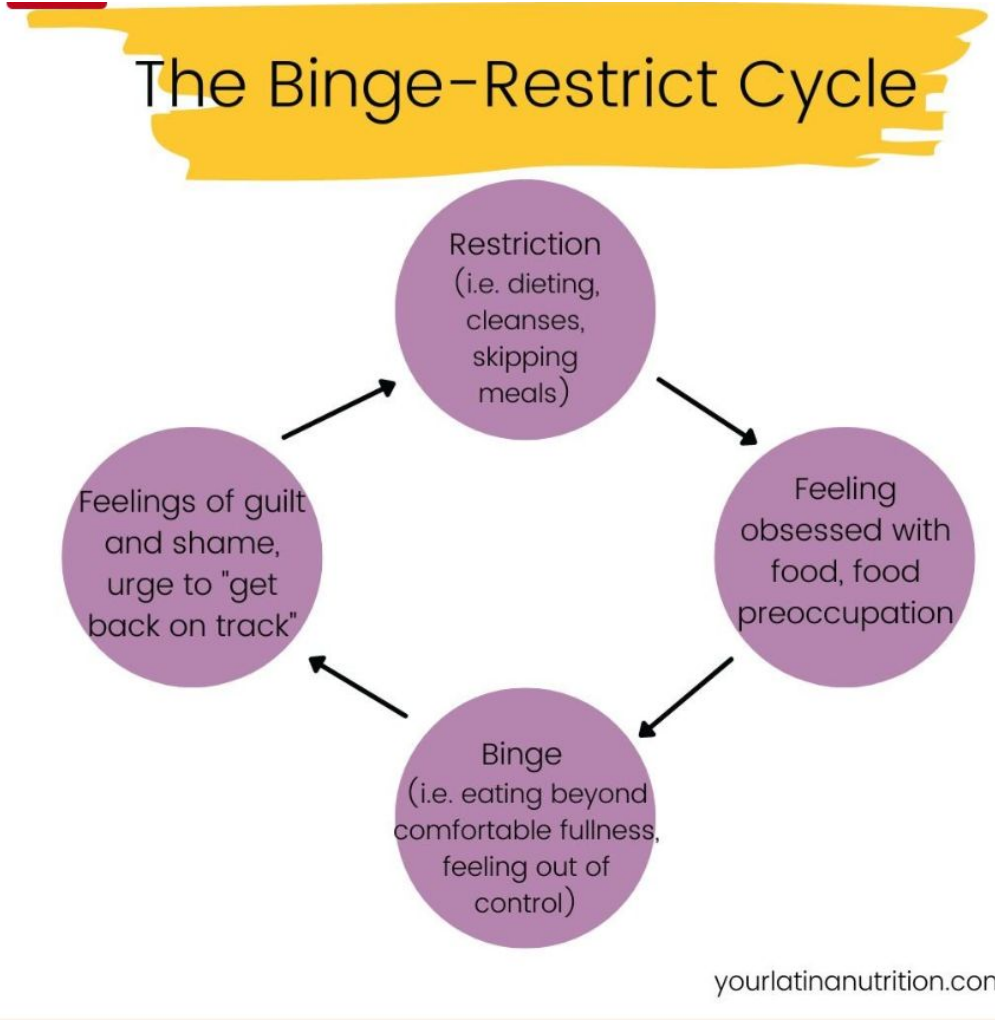


Rather than focusing on differences, eating disorders often share common underlying mechanisms

- You've probably heard: perfectionism, emotion dysregulation, interpersonal difficulties, etc.
- **Restriction** is a common factor among diagnoses and often perpetuates disordered eating

Ancel Keys' Semi-starvation Study (1950) demonstrates the effects of semi-starvation on people, regardless of underlying psychopathology

- Consider: food insecurity and food access, rather than just "self-imposed" restriction"



Medical/Physiological Considerations

Psychological AND physiological illnesses

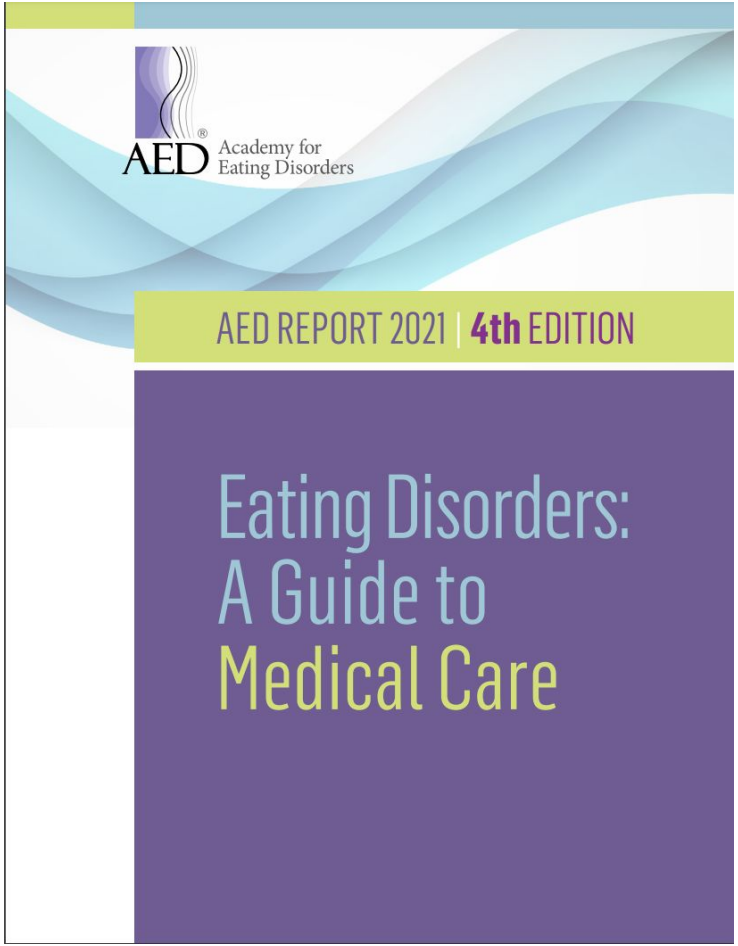
- Eating disorders are the second most deadly mental illness, behind Opioid Use Disorder, due to medical complications and suicide risk (Arceleus, et. al, 2011)
- Short term and long term effects can impact many functions in the body: cardiac, skeletal, hormonal, gastrointestinal
    - Impacted regardless of weight
    - Less than 6% of folks with eating disorders are medically underweight (BMI under 18). (Flament, et. al, 2016)
- Many functions can recover/heal with recovery; however bone loss is permanent and
- we don't have enough research to really know how long term functions are specifically impacted by the eating disorder

Psychological and Physiological Illnesses

- Egosyntonic nature of anorexia- sufferers align with the eating disorder and/or the “results” produced or hoped for with ED behaviors
    - Talking about health concerns with folks who are struggling is really important from an informed consent perspective, and it may not have the desired effect
- Often referred to a **mental health provider** (which is great!), however:
    - Only treating “underlying” psychological issues may not help someone heal
    - Careful medical management should be undertaken to prevent death, long term complications, and to assist growth (if someone is a child/teen)
    - Intervention can begin anywhere and folks are often screened/caught in sports, dentist offices, PCP offices, etc.

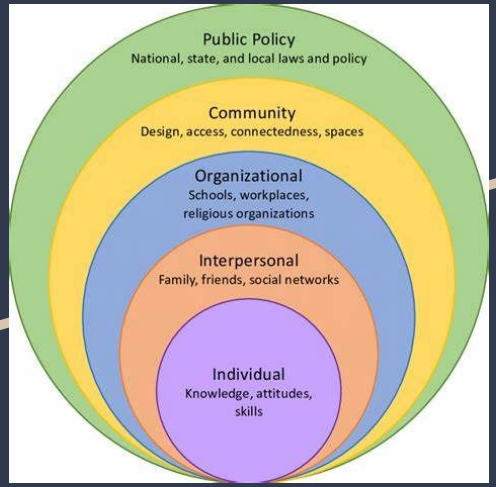
Medical Issues/Medical Standards Guide

- Free guide for providers, clinicians, family members, and patients themselves
- Examination Guidelines
- Labs
- When to Hospitalize
- Subspecialty Concerns: GI, Cardiac, Musculoskeletal, Dermatology, Dental, etc.
- Goals of Treatment
- Nutrition Rehabilitation/Refeeding Syndrome
- Print, have on hand everywhere!



Barriers to Prevention and Care in Central Washington

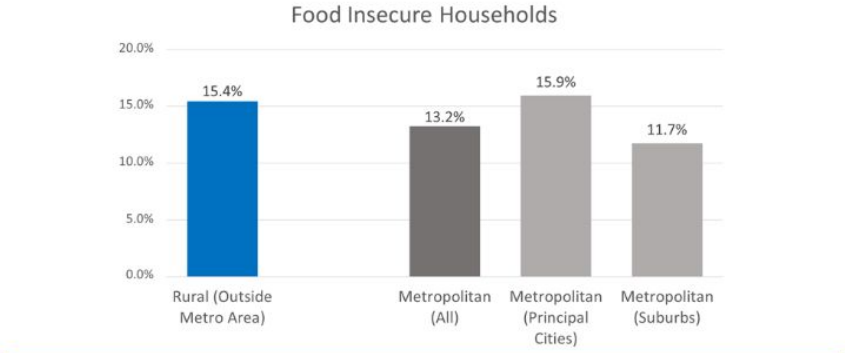
Health Equity Using a Social Ecological Model Approach



- SEM calls for an approach to health behaviors that recognizes the complex, reciprocal, and interdependent societal factors that impact our health
- We are connected to our environment and our environment is connected to us
- Shifts the typical 'blame' paradigm in health promotion to one that recognizes broader contextual influences on health behaviors

Food Access in Rural Areas

- In 2023, **13.5%** of U.S. households experienced food insecurity
- In rural areas, the rate rose from **14.7%** in 2022 to **15.4%** in 2023
- Risk of food insecurity increases as counties become more rural
- Consider access to food and relationship/contexts for eating disorders



Source: Household Food Security in the United States in 2023

Systemic Barriers to Prevention and Care in Rural Areas

- Factors to consider:
  - Food Access
  - Poverty
  - Healthcare Access in Rural Areas
  - Post pandemic context

- Eating Disorder Treatment
  - Lack of specialized providers
  - Bias
  - Higher Level of Care centers thin, white, cis women (Minaya, 2025)
  - Only in larger cities
  - Interventions can be carceral and lack cultural humility, sensitivity, and nuance

- Overlap in theoretical frameworks and approaches for systemic and individual level approaches to understanding eating disorders

Eating Disorders and Marginalized Populations

Who do you immediately picture when you think of someone with an eating disorder?

Eating disorder care has been centered around:

- Thin
- White
- (cis)women
- concerns primarily revolve around fear of gaining weight and the thin white ideal

Eating Disorders in Communities of Color

- Hispanic/Latina/o, Black/African American, and Asian Americans are **more likely** to engage in disordered eating behaviors than their white counterparts. (Simone, et. al, 2022)

- Adolescents who experience racial/ethnic discrimination are **3x more likely** to have binge eating disorder than those who have not experienced racial/ethnic discrimination. (Raney, et. al, 2023)

- Understanding perceptions of body types in different cultural contexts

Eating Disorders in Communities of Color

- **People of color with eating disorders are half as likely to be diagnosed or to receive treatment. (Parker et. al, 2022)**
- Youth of color are less than two thirds as likely to receive recommended treatment compared with white youth. (Sonneville & Lipson, 2018)
- A recent meta analysis found that the odds of adults having binge eating if they experience food insecurity are 1.66 times the odds of adults having binge eating if they have food security. (Egbert et. al, 2022)

Latine and Indigenous Populations

- Culturally relevant eating
  - health promotion focuses on “western diet” which can affect pattern of eating behaviors
  - Perpetuate negative stereotypes of culture specific foods
- As clinicians
  - What do you perceive as “cultural” foods in the U.S.?
  - Are we approaching our understanding of food from a cultural humility perspective?
  - Are we considering aspects of deprivation and poverty in our approaches?

Immigrant Populations

- Typically referred to as “hard-to-reach” populations
-

Gender

Historically speaking, eating disorder care has been centered around thin, white, (cis)women who's presenting concerns primarily revolve around an intense fear of gaining weight and the thin white ideal.

- DSM-IV criteria explicitly listed loss of menses as criteria for AN, erasing men, nonbinary people, trans women, and other people who do not menstruate for a variety of reasons.
- Social understanding of EDs tied directly to thinness, whiteness, and intense fear of gaining weight.
- HLOC divided by biological sex, conversations about "reclaiming divine feminine" etc.

Eating Disorders & TGNC+2S Individuals

Prevalence rates of ED/DEB among TGD communities are estimated between 2 and 18% according to a review including 20 publications.

- One study (n=1,333 TGD youth) found that approximately 4.3% of transmasculine and 4.2% of transfeminine youth reported a lifetime eating disorder diagnosis.
- Another study found that approximately 18% of trans individuals reported an eating disorder diagnosis in the past year (1.8% of cisgender female youth and 0.2% of cisgender male youth)
- A more recent review (Nagata et al.) estimated TGD people in the United States to have a lifetime prevalence of diagnosed disordered eating at a rate of 10.5% for transgender men and 8.1% for transgender women.
- The most common diagnoses were anorexia nervosa (4.2% for transgender men and 4.1% for transgender women) and bulimia nervosa (3.2% for transgender men and 2.9% for transgender women).

Why might this be? What are your educated guesses?

Factors that contribute to ED prevalence for TGNC folks

To date, the extant body of literature has identified a handful of potential contributing factors for the development ED/DEB pathology, which include:

(1) puberty and gender dysphoria;

(2) cisnormativity and passing; and

(3) barriers to accessing gender affirming healthcare.

Factors that contribute to ED prevalence for TGNC folks

To date, the extant body of literature has identified a handful of potential contributing factors for the development ED/DEB pathology, which include:

(1) puberty and gender dysphoria - TGNC people may feel more body image distress as a result of being transgender outside of an ED experience.

(2) cisnormativity and passing - in a world that is not designed for them.

(3) barriers to accessing gender affirming healthcare - where access to gender affirming care is difficult to come by and often inaccessible.

DSM-V-TR & Gender Dysphoria

Some people who are transgender will experience **“gender dysphoria,”** which refers to psychological distress that results from an incongruence between one’s sex assigned at birth and one’s gender identity. Though gender dysphoria often begins in childhood, some people may not experience it until after puberty or much later.

Cisnormativity & Passing

Cisnormativity: Cisnormativity is the societal assumption that being cisgender (where a person's gender identity aligns with the sex they were assigned at birth) is the norm, often marginalizing and invalidating the experiences of transgender, non-binary, and gender non-conforming individuals.

Passing: In the context of transgender people, "passing" refers to being perceived and treated as the gender they identify with, rather than their gender assigned at birth, often leading to a smoother experience in public and potentially avoiding discrimination

Eating disorders can be a valid (though risky) means of trying to mitigate gender dysphoria, increase euphoria, and also can be an attempt to comply with cisnormativity or be used to reach a goal of “passing” as a particular gender in a world rooted in the gender binary.

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It becomes tricky to assess body image distress within the context of an eating disorder, vs. body image distress related to dysphoria

Barriers to Access to Gender Affirming Care

Some common barriers to GAC include:
1) Geographic Location - Most affirming clinics/surgeons are located in larger cities (we are changing this - give WSHA examples; Peds; PP), and fewer providers are comfortable providing GAC in rural areas

2) Social Location - Insurance companies often create insurmountable barriers to receiving care (e.g. gatekeeping, out of pocket costs, not covering GAC via medicare)

3) Socio-political context - GAC is actively being targeted as a part of Project 2025

Barriers to Access to Gender Affirming Care

Some common barriers to GAC include:
4) Family/School/Work support - Leave policies, supportive (or not) social environments

5) Misinformation - Nobody is having surgery in nurses offices in K-12 settings, and yet a quick google search will show you the chaos out there re: information about GAC

6) Fatphobia - BMI cutoffs continue to be a struggle for folks seeking GAC via surgery, and yet weight gain is a common side effect of HRT (also required for surgeries, often)

7) Racism/Colonialism - EDs & TGNC issues seen as a “white problem” but multiple genders existed pre-colonialism and EDs impact everyone

Unfortunately, ED treatment often erases these nuances

1. Assuming all EDs are the same, and rooted in the thin white ideal. TGNC folks are up against not only the same body image norms and ideals as everyone else in the West, but may have unique pressures (which can be very rooted in safety) that cisgender people don't face.
2. ED treatment is often geared towards thin, affluent white women, and often doesn't hold space for gender expansiveness (e.g. binary tx options).
3. Finding ED care already hard, finding affirming & accessible HLOC can be doubly difficult.
4. Fatphobia / BMI cutoffs.
5. Not allowing folks with EDs to access gender affirming care because it is "the eating disorder" rather than gender dysphoria.

Body Size/Fatphobia

What is weight stigma?

- Prejudicial attitudes toward folks in larger bodies.
- Beliefs and assumptions about discipline, willpower, what and how much folks eat, lifestyles, etc.
- Discrimination in healthcare- beliefs about health concerns being caused by weight or weight gain
- Discrimination and abuse in multiple settings- employment, restaurants, airplanes, grocery stores,

Why is it important to know about it?

- Screening for ED- folks in larger bodies are screened, not believed, or assumed to have Binge Eating Disorder regardless of actual diagnostic findings
- Interactions in Healthcare- health problems blamed on weight immediately, or health problems not taken seriously
- Medical providers and mental health providers struggle with bias, prejudice

Rachel Wiley- The Fat Joke

The Fat Spectrum & Systemic Oppression

A BRIEF EXPLAINER

THE FAT SPECTRUM

The easiest way to visualize the fat spectrum is an arrow pointing up. As your size & weight go up, so do the number of barriers you face.

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FATEGORIES

UNDERSTANDING THE FATNESS SPECTRUM

SMALL FAT

BELOW A US WOMEN'S 18, OR 1X - 2X

This is the smaller end of the fatness spectrum. Small fats can usually straddle the line between "fat" and "straight size." They can face medical discrimination & poor interpersonal treatment but are generally able to participate in public life with few restrictions based on size.

MID FAT

BETWEEN A US WOMEN'S 20 - 24 OR 26, OR 2X - 3X

Typically only able to shop in plus-size stores, with brick-and-mortar shopping options less frequent. At the upper end of many plus-size retail offerings. More visibly fat, they experience more size discrimination in healthcare, at work, and may have trouble fitting into seats and other public spaces.

LARGE FAT

US WOMEN'S 26 TO 32, OR 4X - 5X

The end point for most plus-size clothing, mostly relegated to online options. This term can also apply to anyone at the larger end of the fatness spectrum, though typically they place closer to the middle of the bell curve.

SUPER FAT / INFINIFAT

LARGER THAN A US WOMEN'S 32 BUT ALSO IT'S COMPLICATED!

"Superfat" was created at a NOLOSE conference in 2008 & is meant to describe the largest & most underserved folks in fat communities. They face significant barriers to access in healthcare, clothing, public spaces, workplace discrimination, and beyond. "Infinifat" describes the same group & came into prominence around 2017, via Ash of The Fat Lip Podcast. Her widely-circulated size chart placed "Super Fat" below "Infinifat," which is often how it is used. Usage may vary, but both terms indicate people on the largest end of the spectrum.

DEATH FAT

Term created by fat activist & writer Lesley Kinzel in 2008. The term was not intended to have any specific size range or limitations, & can be used anyone who wishes to reclaim their "morbid" fatness.

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Community Based Prevention and Treatment Strategies

Recall Barriers

- Lack of providers and treatment centers in underserved areas
  - Dietitians and Therapists are wonderful, and without some ED knowledge, sometimes more harm can be done
- Higher Level of Care (HLOC) referrals
  - CAN be life saving!! Important to know about options AND
  - Lack of providers in HLOC who represent patients/clients
  - Lack of facilities and same biases for fat clients
  - Lack of culturally relevant practices and foods
  - Lack of gender affirming care
  - Often far away from client's support system
- Cost of Treatment is Exorbitant
  - Medicaid is often not taken and/or need single case agreements
  - Private pay therapy is approx $150-$200 per hour
  - Eating disorder treatment is often intensive and long term

Goals in Community Based Treatment

- Create enough structure and support so that ED thoughts and behaviors can be interrupted in a culturally competent and trauma-informed way
- Consider sustainability of treatment and services
- Monitor medical complications
- Monitor for crises and safety plan
- Work toward “recovery” as clients define it

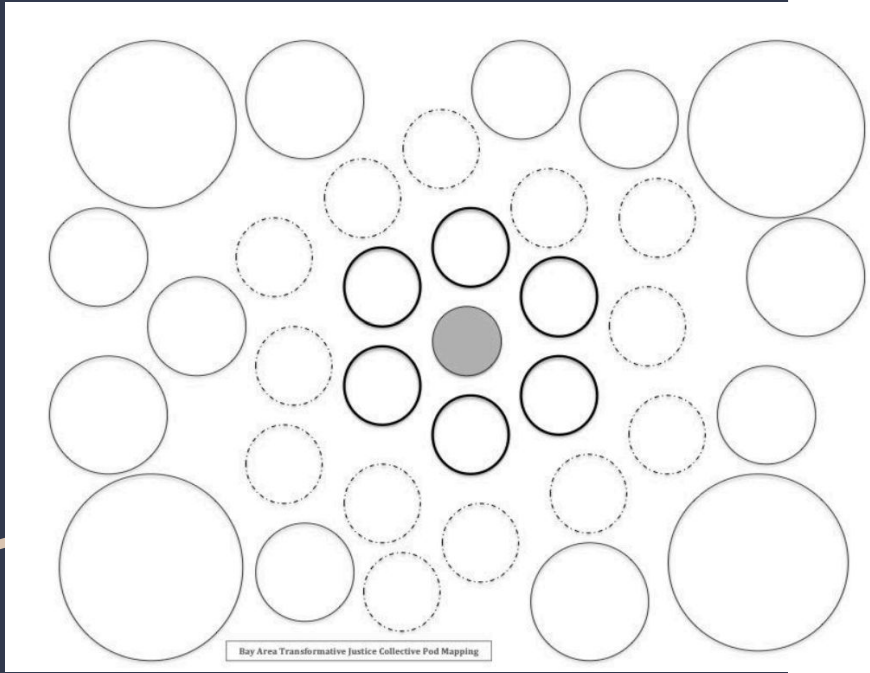
Creating a Treatment Team

- **Traditionally:** a therapist, dietitian, and medical provider who can support your client
- **What happens if this is not accessible?**
- Traditional options to consider:
- Telehealth! Consider inviting folks who practice across the state on your team
- Integrated care/wrap around care may be an easier reach
- Continue to use directories such as: Psychologytoday.com, Open Path Collective, TherapyDen, and your professional networks for referrals.

Creating a “Treatment Team” and accessing care

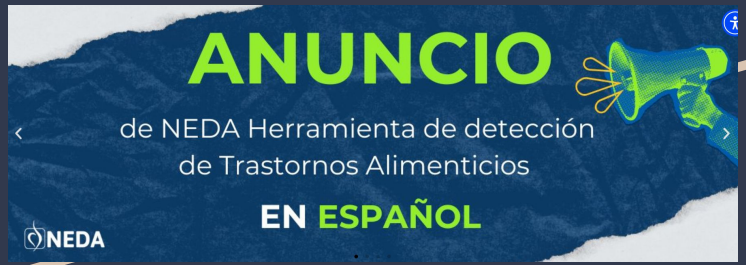
- Culturally Relevant Engagement- communities already have a wealth of resources that can be drawn upon to support individuals (Hood et. al, 2023)
  - Know your communities, your clients, your patients
  - Who can you include? What relevant knowledge might they already hold?
  - Who has built rapport and relationships in the community? Are there opportunities to work with or include these individuals?
- Be direct/transparent/collaborative
- Understand medical mistrust, understand that it takes time to build trust
- Offer services in preferred language
- Being willing to pivot when Evidence-Based Practice (EBP) is not “working” and not labeling folks as “noncompliant”

Creating a “Treatment Team”



- Pod Mapping (Mingus, 2016)
  - Roots in transformative justice, when harm is done
  - Alternative to “creating community,” which can feel nebulous and difficult to to achieve
  - Taking time to name individuals who are close and can assist in a crisis or in specific circumstances (when one needs to take accountability)
  - Individuals who can provide meal support, who can challenge ED thoughts, who can sit with clients when ED thoughts are loud, healers, teachers, mentors, etc.

Education and Advocacy



- Expressing concern early and often about behaviors
- Education IS an intervention. Many folks do not get screened or “caught,” which serves to reinforce that they are not “sick enough” to deserve treatment.
- Remember the AED Medical Guide- knowing about medical concerns can be a huge help for clients and parents.
- **National Eating Disorder Association screeners and information**
- Collaborate - create interdisciplinary teams to disseminate this information is helpful for clinicians but it’s also meaningful for the community

Dear "SOCIAL WORKER NAME"- I need to initiate an intervention for a student presenting with severe eating disorder symptoms that pose immediate health risks.

Student: "STUDENT NAME, and SCHOOL ID NUMBER"

Critical Information:

- Disclosed severe caloric restriction (as low as 20 calories daily)
- 10-pound recent weight loss
- Complete meal avoidance (no breakfast/lunch)
- Severe food anxiety and avoidance
- Two-year eating disorder history, poor response to family interventions, and recent significant deterioration.

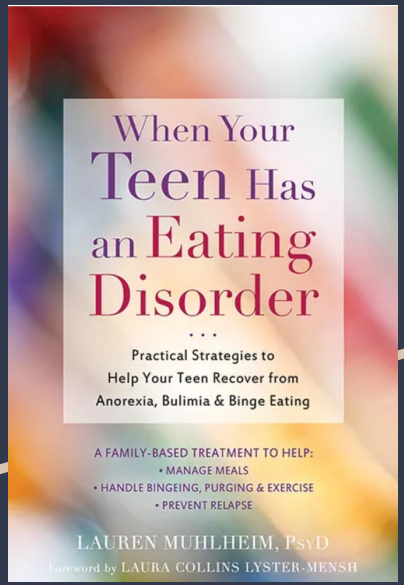
Medical Risk Assessment: This level of restriction constitutes a medical emergency. As you may know, severe caloric restriction can cause:

- Cardiac complications (bradycardia, arrhythmias, sudden cardiac death)
- Electrolyte imbalances leading to seizures or cardiac arrest
- Cognitive impairment affecting academic performance and decision-making
- Bone density loss and growth stunting in adolescents
- Organ dysfunction and metabolic disruption

Immediate Actions Needed:

1. **Family coordination -** Parents contacted for immediate medical evaluation- Already completed via parent square, but there is a language barrier. I have copied the email at the bottom of this message.
2. **Crisis assessment -** Evaluate for risk with PCP and social worker/therapist
3. **Safety monitoring** - Daily check-ins to assess mental state and physical symptoms
4. **Meal supervision** - Coordinate with nursing staff for lunch period monitoring
5. **Academic accommodations -** Cognitive effects may require temporary modifications

Modified FBT (Family Based Treatment



"Gold standard" for teens with anorexia

Empowering parents to implement treatment strategies at home

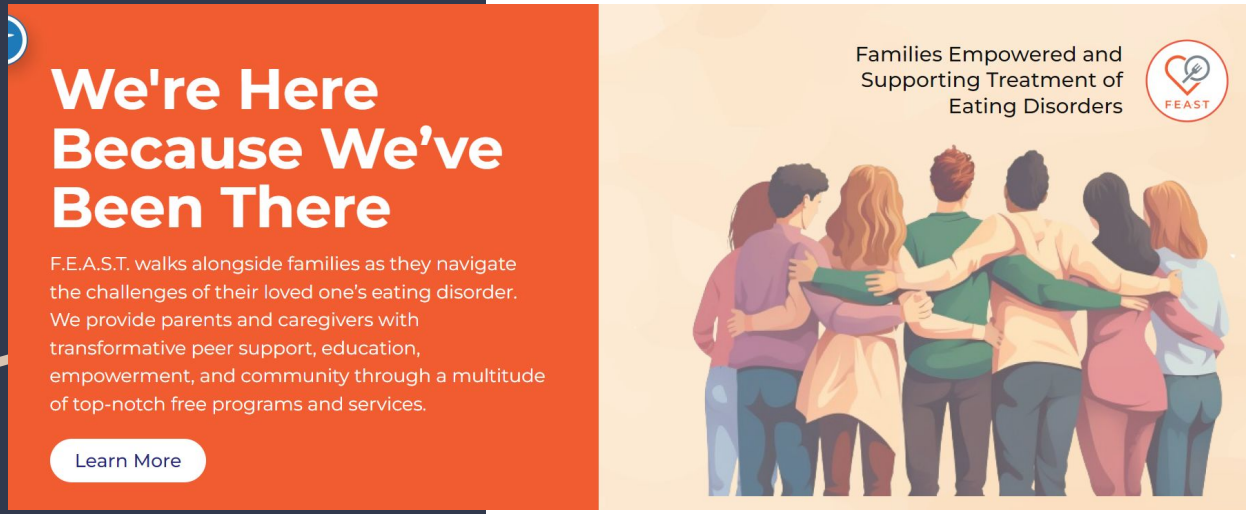
Can utilize culturally relevant foods, practices, and knowledge while providing education about eating disorders

Up the concern about eating disorders and health concerns

Join with the parents to resolve problems, role as expert but not as director

Modified FBT/Parental Support

F.E.A.S.T is an online resource for parents



Harm Reduction

- Harm Reduction
  - Roots in addiction treatment (eating disorders aren't addictions, but useful to frame this way)
  - Emphasizing patient autonomy and person-centered care
  - Focused on minimizing the negative consequences of eating disorder behaviors while acknowledging that complete elimination of these behaviors may not be achievable (yet)
  - Reduces shame, secrecy, and perfectionism
  - Validates that eating disorder behaviors are here for a reason, and likely help your client with something
  - Risk assessment for medical complications and SI, and creating a safety plan for all
    - (If weight drops below x, labs are abnormal, etc. then y will happen)
    - Not brushing teeth after purging, getting regular checkups and labs done,
    - Pod mapping (Mingus, 2016)
- Careful balance of holding hope for "full recovery" and also recognizing that this is very difficult to achieve, and maintaining "abstinence" in eating disorder recovery is impossible

Funding Support

- **Project Heal**
  - Insurance navigation/support
  - Clinical Assessment
  - Funding
  - Help finding providers who provide pro bono or reduced care
- Advocacy
- Single Case Agreements w/Insurance Companies
- Higher Level of Care- work directly with treatment facility

Personal Work

- Awareness of own biases
  - Consider what you previously thought eating disorders “looked like”
- Modeling relationships with food, movement, and body
  - Consider what you say around clients, students, peers about food and body. Is it neutral? Disparaging?
  - How do you relate to food, movement, and body? What are these relationships like? Adversarial? Fraught? Neutral? Enjoyable?

Sonya Renee Taylor- The Body is Not an Apology

Case Study: Option 1

Carlos is a 15 year old who is brought to his primary care provider due to his parents' concerns about weight loss, irritability, and stomachaches. He has told his parents that the stomachaches make it hard for him to eat dishes he has previously really enjoyed, and he normally eats very little or makes himself something different for family dinners. His parents also note that he doesn't eat foods he used to like at family gatherings. Carlos wants to join the cheer team this year, and identifies as one of the few LGBTQ+ students in his rural high school. Carlos' PCP notes that his heart rate is in the 50s, and his BP is slightly lower than usual, but otherwise he appears to be healthy. Carlos' parents are both farmworkers who work long shifts. Carlos has an older sister and two younger brothers.

Case Study: Option 2

OJ (they/he) is a 25 year old trans masculine nonbinary individual with a BMI of 35. He self identifies as on the fat spectrum, and has no significant physical health concerns outside of his BMI being classified as overweight. He was recently denied top surgery due to a BMI cut off of 35. There are no other surgeons within a 3 hour radius of where he lives, and the BMI requirement is required by both the surgeon and their insurance company. OJ has a history of over-exercising, and binge eating after long periods of restriction. While trying to follow his surgeons prescribed diet plan, OJ finds themselves turning to their eating disorder for “relief and comfort.”

Questions to Consider

- How might you approach this case now, knowing what you know? What, if anything, changed for you after this presentation?
- What community resources might you want to leverage? What individual/family/community partner resources might you want to consult?
- Consider your own community
  - Who is typically not considered when it comes to eating disorder prevention and treatment?
  - What are barriers to care in your ecosystem?
  - What resources can you leverage?
  - What ideas has this presentation sparked for you?

Tools & Resources

NEDA* Eating Disorder Screener (En/Es) - https://www.nationaleatingdisorders.org/screening-tool/?lang=es

EQUIP Screener - https://equip.health/is-it-an-eating-disorder

EDE-Q - https://www.corc.uk.net/media/1273/ede-q_quesionnaire.pdf

SCOFF -https://www.childrensmercy.org/siteassets/media-documents-for-depts-section/documents-for-health-care-providers/block-clinical-practice-guidelines/scoff-questionnaire-for-childrens-mercy.pdf

AED Medical Guide - https://www.aedweb.org/resources/publications/medical-care-standards

Questions?

For slides, email buffum_c@heritage.edu

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