2021

The Risks for Eating Disorders/Disordered Eating in Refugee & Immigrant Experiences and the Imperative of Culturally Alert Screening

Chantal A. Bushelle
University of Denver

The Risks for Eating Disorders/Disordered Eating in Refugee & Immigrant Experiences and the Imperative of Culturally Alert Screening

Abstract

Eating Disorders (ED)/Disordered Eating (DE) largely remain outside of global mental health agendas. There are limited data on the epidemiology EDs/DE in refugee and immigrant populations, and there is a paucity of research on refugee and immigrant experiences of EDs/DE. Study of acculturation issues in refugee and immigrant populations have historically missed investigating what role and impact experiences of stress and trauma (e.g., historical, chronic) along with cultural change and transition may have on their food attitudes and eating behaviors. While there has been some study of eating habits within refugee and immigrant populations, the focus is typically on food acculturation with regard to the consumption of foreign foods and, in some cases, the highlighting of new-to-population physical health concerns, such as diabetes, cancer, and cardiovascular disease. Screening and treatment for EDs/DE has historically attributed them to a stereotyped White, female, Western-world, and middle-class phenomenon. This myopic focus has potentially created a health disparity for refugees and immigrants in general, and specifically for non-White members of these populations, from the resulting lack of research and screening for EDs/DE risks in these communities. Mental health clinicians and humanitarian organizations can be better equipped to screen, assess, and treat refugees and immigrants through recognizing how problematic ED/DE behaviors can emerge from the intersection of societies in transition, acculturative stress, social suffering, trauma/PTSD, and interpersonal disruption within their experiences.

Document Type

Doctoral Research Paper

Degree Name

Psy.D.

Department

Graduate School of Professional Psychology

First Advisor

Gwen V. Mitchell

Second Advisor

Judith E. Fox

Third Advisor

Tamara Pryor

Keywords

Acculturative stress, Anorexia nervosa (AN), Binge eating disorder (BED), Bulimia disorder (BN), Disordered eating (DE), Eating disorders (EDs), Immigrant, Refugee, Social suffering, Trauma, PTSD

Subject Categories

Clinical Psychology | Epidemiology | Health Policy | Health Psychology | International Public Health | Medicine and Health | Migration Studies | Psychology

The Risks for Eating Disorders/Disordered Eating in Refugee & Immigrant Experiences and the Imperative of Culturally Alert Screening

A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
OFFICE OF GRADUATE STUDIES
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
CHANTAL A. BUSHELLE, M.A.
June 04, 2021

APPROVED:

Gwen V. Mitchell, Psy.D. (Chair)

Judith E. Fox, Ph.D.

Tamara Pryor, Ph.D., FAED

Acknowledgements

"Our ancestors are an ever widening circle of hope." Toni Morrison

I am here because of all those who have gone before me. I wholeheartedly thank my parents for exposing me to an extraordinary U.S. Foreign Service life growing up overseas as a Third Culture Kid. Consequently, my worldview is global, and I strive to incorporate diverse perspectives and social justice considerations in all of my clinical work.

I am grateful for my two beautifully vivacious young boys, who have been my loudest cheerleaders and my sharpest reality checks.

Never-ending gratitude to my partner in life, who sees me, holds me, encourages me, and walks by my side, always.

I would like to thank my doctoral paper committee, Dr. Gwen V. Mitchell, Dr. Judy Fox, and Dr. Tamara Pryor, for their expert guidance, kind support, and grace through my doctoral paper journey.

Abstract

Eating Disorders (ED)/Disordered Eating (DE) largely remain outside of global mental health agendas. There are limited data on the epidemiology EDs/DE in refugee and immigrant populations, and there is a paucity of research on refugee and immigrant experiences of EDs/DE. Study of acculturation issues in refugee and immigrant populations have historically missed investigating what role and impact experiences of stress and trauma (e.g., historical, chronic) along with cultural change and transition may have on their food attitudes and eating behaviors. While there has been some study of eating habits within refugee and immigrant populations, the focus is typically on food acculturation with regard to the consumption of foreign foods and, in some cases, the highlighting of new-to-population physical health concerns, such as diabetes, cancer, and cardiovascular disease. Screening and treatment for EDs/DE has historically attributed them to a stereotyped White, female, Western-world, and middle-class phenomenon. This myopic focus has potentially created a health disparity for refugees and immigrants in general, and specifically for non-White members of these populations, from the resulting lack of research and screening for EDs/DE risks in these communities. Mental health clinicians and humanitarian organizations can be better equipped to screen, assess, and treat refugees and immigrants through recognizing how problematic ED/DE behaviors can emerge from the intersection of societies in transition, acculturative stress, social suffering, trauma/PTSD, and interpersonal disruption within their experiences.

Keywords: Acculturative Stress, Anorexia Nervosa (AN), Binge Eating Disorder (BED), Bulimia Disorder (BN), Disordered Eating (DE), Eating Disorders (EDs), Immigrant, Refugee, Social Suffering, Trauma/PTSD

Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), as of mid-2020, 80 million people around the world have been forced to flee their homes, and, of this group, 26.3 million were refugees (UNHCR, n.d.). For 2019, the UNHCR reported 107,800 refugees were resettled worldwide, and 31,250 refugees were resettled in the United States (U.S.) (UNHCR, n.d.). There were 44.8 million immigrants living in the U.S. as of 2018, comprising 13.7% of the population, with 40-44-year-olds representing the largest age group. Beginning in 2010, more Asian immigrants exceeded Hispanic immigrants in annual arrival to the U.S. (Budiman et al., 2018). Since the beginning of January 2021, the U.S. government has cited 25,000 active cases from asylum-seekers at the U.S. Southern border being held in Mexico while awaiting decision (Verza, 2021).

Previous research on the transition process for refugee and immigrant populations has focused primarily on acculturative stress. Saccone & Obeng (2015) highlighted that over the past few decades a number of studies have examined international college students' acculturative stress through issues such as culture shock, role expectations and confusion, lack of social support and self-efficacy, and language barriers. They found that individuals experiencing significant amounts of acculturative stress typically encounter a deterioration of overall health status. One of the many health-related changes that often occurs with immigration is change in diet. Dietary acculturation, which is the process whereby individuals of a minority group adopt eating patterns and food choices representative of their host country, can result in both healthful and detrimental dietary changes. Additionally, Claudat et al. (2016) found in their study of Latina and Asian-American female college students in the U.S. that acculturative stress and low self-esteem may contribute to the development of disordered eating (DE). They highlighted the

importance of addressing acculturative stress and self-esteem in the assessment and treatment of eating disorders (EDs) in women of ethnic minority groups and recommended assessing for eating pathology when ethnic minority women present in clinical contexts with difficulties associated with acculturative stress. Furthermore, Saccone & Obeng (2015) contended the nutritional health and wellbeing of international college students in the U.S. remains understudied despite the fact that it would support the goal of general academic success.

Acculturation research on eating stressors for refugee and immigrant populations has largely been based upon the difference in food choices and changes in dietary patterns. Consequently, food acculturation study in these populations in the U.S. has focused primarily on physical health and associations with changing health concerns (e.g., increased risk for obesity-related conditions and chronic diseases) due to new diets (Patil et al., 2010). Although previous studies have attributed the shift to unhealthy dietary patterns, often characterized by an increase in the consumption of fat, sugar, and salt, to issues of food choice in refugee and immigrant transition and acculturation, Ross et al. (2017) found in their study with Liberian refugees that dietary pattern adherence was not associated with time spent in their settlement or necessarily attributed to food differences and changes. Furthermore, the Liberian refugees' diet did not become similar over time to their host country, Ghanaian diet. The researchers found that other more complex experiences, such as exposure to marginalization, food insecurity, conflict, and violence, during the Liberian refugees' migration may have been influential and detrimental to their dietary intake. This finding suggests that other factors are likely involved in refugee and immigrant experiences of food acculturation.

Refugee and immigrant experiences of cultural transition may also permeate through generations. Franzen & Smith (2009, as cited in Ross et al., 2017) and Kasemsup & Reicks

(2006, as cited in Ross et al., 2017) found that among Hmong immigrants resettled in the U.S., parents and grandparents tended to overfeed their children in response to the threat of food deprivation and stress they had encountered during their time in refugee camps. According to Swanson et al. (2011) in a study of migration from Mexico to the U.S., risk for binge eating increased across immigrant generations in the U.S. without corresponding changes in the ED-related symptoms associated with these behaviors. Increased exposure to the U.S. was associated with increased rates of binge eating and Binge Eating Disorder (BED) with the incidence of these behaviors more significantly elevated in U.S.-born Mexican–Americans with two U.S.-born parents. This finding suggests that the transgenerational cultural change underlying the increase in EDs/DE risk may occur relatively slowly. The researchers also found that increase in risk for binge eating may not be due solely to specific cultural pressures (e.g., differential body image ideals) but rather in large part to non-specific factors that are connected with changes in a range of mental health morbidity (e.g., anxiety/depression) associated with generational migration.

Similarly, Alegria et al. (2007) found that acculturation with generational transmission has contributed to risk for EDs/DE in the U.S. Latino population. Latinos have elevated rates of binge eating and BED but low prevalence of Anorexia Nervosa (AN) and Bulimia Nervosa (BN). U.S.-born Latinos, and those who have lived a greater percentage of their lives in the U.S., evidenced higher risk for certain eating disorders. Additionally, the researchers asserted that standard eating disorder criteria may not be appropriate for understanding DE for less acculturated Latinos and that further research is needed to evaluate how to establish criteria for assessing ED/DE patterns as well as to investigate whether certain diagnostic criteria, such as

fear of weight gain or body dissatisfaction, should be excluded for immigrants and less acculturated Latinos.

Recent research from data generated through "Google Trends," a tool that assesses the relative search volumes of keywords and topics, found that worldwide data collected from January 1, 2004 to December 31, 2016 revealed the topics "Anorexia Nervosa" and "Bulimia Nervosa" were in the top 10 of search volume for Latin American countries, with Mexico ranking first until 2016 when Bolivia rose to the top of the list. The results revealed that AN and BN are issues of considerable and consistent salience across Latin America (Karin, 2018). Although Google Trends is not an epidemiological instrument, it has been applied widely in health-related research. Moreover, Google Trends is considered useful in epidemiology because it allows for real-time and seasonal tracking of health-related symptoms and behaviors in conjunction with long-term assessment of trends in public interest and conceptualizations of particular diseases and disorders (Nuti et al., 2014, as cited in Karin, 2018). EDs/DE have global distribution and are increasingly likely contributors to the burden of illness in populations undergoing migration, urbanization, or rapid economic development (Becker, 2003 as cited in Becker et al., 2010).

Finally, the role of mental health clinicians working with refugee and immigrant populations is to consider the various ways individuals manifest their phenomenological experiences. There has been historical precedent in psychology to view members of minority populations as members of a group whose development is shaped primarily by culture but to perceive members of majority populations, and specifically White individuals, as independent with their development being largely influenced by personal psychological processes (Causadias et al., 2018). Screening, assessment, and treatment measures must consider individual cultural

factors in conjunction with the benchmark therapeutic 'common factors' when working with refugees and immigrants. Cultural incompetence can occur when linguistic translations try to conform to the exact terms of standardized instruments or when concepts are uncritically transferred across cultures (Le Grange et al., 2004). Assessment problems are compounded by the lack of sensitivity to cultural norms in evaluation materials that have been translated into refugee native languages. As a result, assessment of refugee and immigrant psychological distress has historically proven challenging due to the various methodologies and range of measures that render it difficult to generalize across studies (Bolton, 2019). Recognition and knowledge of these disparities in screening and assessment procedures may inspire mental health clinicians to explore refugee and immigrant experiences of food and eating for comprehensive treatment during transition and resettlement.

Biopsychosocial Factors in the Development of EDs/DE

EDs/DE have individual, family, socioecological, and biological origins, pointing to a biopsychosocial etiology. Maladjustment to environmental stressors can initiate their development as can chronic stress and traumatic events. One supposition is that DE is the body's normal attempt to cope with abnormal situations of modern stresses, cultural ideals, and food availability. From this perspective, DE is actually a discrepancy between prehistoric physiology and modern lifestyle demands (Andrews, 2015). EDs/DE can also reappear during periods of life transitions (e.g., adolescence, mid-life, identify and lifestyle changes, stressful personal events) and then disappear again for a while when things settle down (Andrews, 2015). Notably, EDs/DE can also take root when a family hierarchy is turned upside down due to a family

stressor(s). Parents often lose control during this period and the ED is allowed to spin out of control. Re-establishing a normal hierarchy where parents are in-charge is a major goal in recovery (Frank, 2016). Increases in daily stressors, including of cultural norms and significant familial role changes, are typically present in many refugee and immigrant experiences of transition and may elevate risk for EDs/DE.

According to Frank (2016), the biological traits associated with developing an ED are a disposition to heightened anxiety, increased sensitivity to salient stimuli, and a smaller or larger orbitofrontal cortex, which could alter an individual's ability to stop eating when physiologically satiated. Additionally, individuals susceptible to developing EDs/DE have abnormal dopamine circuits, which regulate movement and important cognitive functions, such as motivation, reward associations, and habit learning. Therefore, individuals who develop AN may be particularly sensitive to occasions when there is less food eaten, for instance, during food insecurity and shortages. This may cause their dopamine circuit to become overly sensitized to a point where stimulation is perceived as excessive, which then results in their eating restriction.

Similar to AN, BN is associated with high cognitive control, anxiety, and sensitivity to salient stimuli; however, the opposite occurs with regard to how dopamine circuits manifest. These individuals may be more sensitive to excessive food intake, which may result in their cognitive control becoming overridden by a desensitized dopamine system leading to binge behaviors followed by cognitive compensation through purging behaviors. BED may be biologically characterized by a desensitization of dopamine circuits to excessive food combined with a weaker cognitive control mechanism, which would make it difficult for an individual to stop eating even when physiologically satiated (Frank, 2016). Consequently, BN and BED behaviors may also be impacted by chronic fluctuations in food availability.

Trauma and Stress in Refugee & Immigrant Experiences

Refugees and immigrants are susceptible to high levels of daily stress and can be at increased risk for acute and chronic traumatic stress reactions given potential experiences before, during, and after flight from their homes/countries (Williams & Berry, 1991). Pre-displacement experiences of trauma (e.g., war and political violence, natural disaster, grief and loss, deprivation - including from food, child abuse, sexual abuse, and domestic violence, physical illness, and mental health issues) may contribute to overall psychological distress (Miller & Rasco, 2004). During flight from their homes/countries, additional hardships (e.g., chronic lack of shelter and food, interpersonal violence, interrogations, sexual assault, and kidnapping) may be encountered while in transit (Boston Children's Hospital., n.d.). Subsequently, displacement-related daily stressors can include a loss of social networks, previously valued social roles and role-related activities, unemployment, a lack of educational resources, and poverty (Miller & Rasco, 2004).

According to Pappas (2019), changing roles in refugee and immigrant experiences include daughters having to help take care of their families by, in some cases, prioritizing earning money over schooling, which can exacerbate daily stressors. Often children are also responsible for being their parents' translators and engaging in their business affairs. Refugee and immigrant resettlement can present compounded potential risks and dangers involving community and gang violence, hate crimes and xenophobia, family separation, and threatened or actual deportation (Boston Children's Hospital., n.d.). The combinations of acculturative and resettlement stressors can heighten trauma-related reactions and increase feelings of isolation and general loss of control, which may have implications for the development of problematic feeding and eating behaviors. Reyes-Rodriguez et al. (2011, as cited in Anderson et al., 2018) found

bingeing and purging behaviors appear to be more associated with trauma/PTSD than food restriction; however, the prevalence of trauma exposure and PTSD also appear to be greater in restricting-type AN than in the general population.

A significant reaction to experiences of trauma and chronic stress is humiliation. According to Mollica (2006), a feeling of humiliation can result from an experience of violence. Perpetrators seek to evoke a fundamental feeling of worthlessness in their victims. Humiliation is comprised of a combination of physical and mental inferiority, shame, and guilt. In refugee and immigrant experiences, humiliation can be inflicted by both interpersonal acts as well as through public degradation of one group by another. Feelings of humiliation are often transformed to the more acceptable, visible, and researched emotions of anger, grief, and despair, and, thus, may not be as detected in screening or explored and treated clinically. Furthermore, Troop et al. (2008) found that shame as a perception that others view the individual as inferior (external shame) was uniquely associated with severity of AN symptoms, particularly the degree of underweight. By contrast, internal perceptions of shame, characterized by negative feelings about the self, was uniquely associated with severity of BN symptoms, particularly the over-concern with body weight and shape. Although the women in the study who were in remission from an ED reported significantly lower levels of shame than those who were currently ill, they still continued to report significantly higher levels of external shame than the non-clinical sample.

EDs/DE and Transcultural Anthropology

According to Pike & Dunne (2015), EDs/DE are culture-reactive and not culture-bound or -specific. Thus, individuals may be affected by activity or change in their cultures from both

within and without its borders. Although EDs/DE have traditionally been considered primarily Western culture disorders, recent research indicates significant prevalence outside of this cultural historic norm and has pointed to other understandings of ED/DE behaviors. For instance, Aoun, Garcia, Mounzer, Hlais, Grigioni, Honein, & Déchelotte (2013) found a similar or even higher prevalence of EDs/DE in Middle Eastern countries sharing several common cultural features.

Early formulations of AN in transcultural psychiatry designated it as a 'Western culture-bound syndrome' (Prince, 1985; Swartz, 1985; DiNicola, 1990, as cited in Eli & Warin, 2018), and anthropological research in the 1990s problematized Western culture in AN presentation, attributing it partly to Christian religiosity that informs self-starvation (Banks, 1992, as cited in Eli & Warin, 2018). The research and debate in transcultural psychiatry eventually called into question the labelling of AN as a 'culture-bound syndrome' by introducing the concept of 'non-fat phobic anorexia' to capture forms of AN found among patients in China and Hong Kong (Eli & Warin, 2018). Layers of cultural meaning can be uncovered in anthropological research on EDs/DE that often transcend concerns with body ideals, media messages, and health & wellbeing. Anthropology can elucidate how overlooked aspects of culture, such as spatial, relational, sensory, and ideological considerations, shape ED/DE behaviors and influence treatment outcomes (Eli & Warin, 2018).

A study of disordered eating among young Fijian women found that the women aspired to televised images of thinness predominately as successful models of individuality, which became an emerging cultural value as Fiji rapidly shifted toward globalization (Becker, 2004, as cited in Eli & Warin, 2018). For these women, there was a perception that managing their weight through DE behaviors would help support an increase in social and economic opportunities (Becker, 2010). Previous assumptions of acculturation that included notions of 'culture', absent

any contact, as being intact, static, and/or monolithic have become accepted as flawed (Guarnaccia, 2001; Hunt, Schneider, & Comer, 2004, as cited in Becker, 2010). Similarly, a study carried out in a rural Ghana found media images of thin models were not responsible for encouraging AN among young girls and that ED/DE behaviors there may not exist due to Western influences. Instead, the six girls, who were secondary students from various backgrounds and had access to resources and food, were found to have low weight caused by self-imposed diets. The girls cited various reasons for dieting, which included in times of stress, religious fasting, and for feelings of self-control (BBC News, 2000).

In another study involving culture and context, food-related anxiety stemming from a 'lump in the throat' feeling was found not to be a drive for thinness or a fear of fatness but rather a learned avoidance response that generalized from one specific predicament to any context concerning food and eating. The young Italian woman in the study was a foundling child, who was challenged by issues of identity, attachment, anxiety, and mood, and had recently emigrated to Canada to live with her male partner. This move and change may have triggered her ED/DE behaviors as she was displaced from her culture of origin. Although a combination of social stressors and cultural values may have contributed to this young woman's individual suffering, it was important in her assessment and treatment to also consider the effects of her personal values, as positive individual values are instrumental to recovery (Di Nicola, 2020). Employing a transcultural anthropological approach to understanding EDs/DE can assist with understanding the etiology of various ED/DE presentations and prove crucial for successful screening in refugee and immigrant populations.

Risks for EDs/DE in Refugee & Immigrant Experiences

War and Historical & Transgenerational Trauma

Experiencing war is among the most stressful life events and has been associated with increased incidences of anxiety, depression, and post-traumatic stress (Hoge et al., 2004; Fiedler et al., 2006; Black et al., 2004, as cited in Aoun, Garcia, Mounzer, Hlais, Grigioni, Honein, & Déchelotte, 2013) as well as EDs/DE in military populations (McNulty, 1997, as cited in Aoun, Garcia, Mounzer, Hlais, Grigioni, Honein, & Déchelotte, 2013). In a study of Lebanese university students, modification of eating behaviors related to wartime stress was associated with an increased risk of EDs/DE in this population that has been exposed to chronic war conflict. An important finding from this study emphasized that early detection and treatment of EDs/DE may be greatly improved by routine evaluation of eating behavior modification in individuals with histories of exposure to war (Aoun, Garcia, Mounzer, Hlais, Grigioni, Honein, & Déchelotte, 2013).

Comparable to the Lebanese university student study, a study of Syrian refugees living in North Lebanon found that individuals screened with PTSD were three times as likely to also have a positive screen for EDs/DE (Aoun, Joundi, & El Gerges, 2019). The Syrian Civil War, which started in 2011, has led to widespread social instability and physical migration producing tumultuous societal change. According to the researchers, this was the first study that examined the proportion of positive screens for EDs/DE among refugees and results indicated there was a significant association between positive EDs/DE screens and what they termed major Stressful Life Events (SLE).

There are some interesting patterns to be investigated concerning historical war/civil conflict trauma and its association to risk for EDs/DE. During World War II (WWII), Audrey Hepburn lived as an adolescent with her family in The Netherlands and remembered how, during the food shortage, her mother struggled to put meals on the table. Hepburn recalled she began to resent food and became angry with the difficulty in its acquisition. She resolved to 'master' her relationship with food and eliminate her need for it. Hepburn went on to battle EDs/DE her entire adulthood (Maychick, 1996). Holocaust survivors have reported transgenerational trauma that features family histories of EDs/DE. According to Chesler (2005), the participants, and many of their siblings, in their study whose parents had either fled Europe at the onset of WWII or had survived in a Concentration Camp (CC) were found to exhibit restrained or overeating behaviors. The participants' eating behaviors appeared to be related to specific parental eating beliefs and behaviors stemming from personal experiences of deprivation and traumatic events during the Holocaust. Parents of restrained eaters were reported to be preoccupied with their personal thinness yet equated their children's overweight status while growing up with being healthy and a means of protection for them. The trauma the participants' parents experienced fleeing Europe and their transition to other countries may have constituted risk factors for their offspring's development of childhood overweight issues and their later formation of underweight and chronic food restriction in adulthood. Notably, overeaters' survivor parents did not flee Europe and were primarily in CCs during the Holocaust. These study findings suggest that the messages and beliefs regarding food that were passed down to participants from their parents were stronger determinants of their ED/DE behaviors than their parents' own eating practices.

20+ years after the Bosnian War, Šerifović et al. (2005) found in their study that Bosnian women living in both rural areas and cities had experienced significant war stress, and their

perceived level of stress directly affected how they viewed and felt about their bodies. They found a positive correlation between stress and body dissatisfaction, which demonstrated that when stress increased body dissatisfaction also increased. Stress often leads to feeling out of control, and the researchers hypothesized that the study participants attempted to exert control over their bodies as a way to mitigate their stressful environmental experiences.

Likewise, 20+ years after the Rwandan Genocide, where hundreds of thousands of people were brutally slaughtered, cultural experts contend idealization of thinness has become a new trend. While EDs/DE remain largely undiscussed and undocumented in the country, as there are no statistics on the prevalence of AN, the changing Rwandan ideal of beauty is being demonstrated in various beauty pageants where the expectation is on low body weight. However, traditionally and pre-genocide, Rwandans did not favor thinness (Nyirabihogo, 2014).

Societies in transition coupled with traumatic histories can trigger EDs/DE (Simmons, 2002). South Africa is a country in transition, and, significantly, after the end of their Apartheid era, EDs/DE have surfaced among the next generation of South Africans. Le Grange et al. (2004) assert that in the changing socio-historical context of post-Apartheid South Africa, non-White South Africans may not be immune to EDs/DE pathology. EDs/DE risk and vulnerability in their model is tied less to the pursuit of a thin ideal and more to a reaction to the redefining of traditional values. The researchers highlighted acculturation issues due to new Western influences, changing gender roles, and frustration with continued racial inequities as potential EDs/DE risk factors in this population. One of their study participants described not allowing food in her stomach due to her cultural beliefs, and she induced vomiting as part of an internal cleansing ritual to protect her body from sickness. Another discovery in the study was that laxative use was quite common among the participants to prevent constipation given the high

carbohydrate content of their traditional foods. Therefore, Le Grange et al. (2004) maintained reasons for ED/DE behaviors in South Africa were a result of changing cultural values and contextual circumstances as opposed to concerns about slenderness or other body shape issues.

Israel is another society in transition and has been embroiled in civil war since its birth in 1948, with continued vacillations between conflict and peace. According to Latzer et al. (2008), exposure to the chronic risk of war and terrorist threat may increase risk-taking behaviors in Israeli adolescents, including those related to food and eating. In addition, eating-related pathology in Israeli-Arab/Bedouins was noted due to potential stressful experiences from their culture in conflict and transition. Latzer et al. (2008) also shared the example of Hong Kong as another society in transition with great socio-cultural upheaval and changes relative to other parts of China since WWII, and they point to the recent increases in incidents of EDs/DE there (Keel & Klump, 2003, as cited in Latzer et al., 2008) as significant indicators of the link between historical war/civil conflict trauma and the risks for EDs/DE.

EDs/DE and Social Suffering

EDs/DE can be regarded as an existential issue in how it often embodies the concept of control. Control of one's body and emotions along with the ultimate control of one's survival. Eli (2018) introduced a compelling finding in her study of the connection between EDs/DE and social suffering. According to Eli (2018), social suffering refers to oppressive societal factors, structural violence, and institutional constraints, which can all be connected to an individual's experience of lack of control. Transforming these structures and institutions that reinforce social inequality and injustice can be instrumental in addressing social suffering. Social suffering understands embodied distress as intertwined with challenging social ways of being and is not

merely relegated to the individual. Consequently, EDs/DE in social suffering is shifted away from being an individualized, biomedically-defined diagnostic phenomenon and toward a lived individual experience as it is shaped intersubjectively. Moreover, Eli (2018) contends EDs/DE constitutes a form of social suffering where individuals embody liminality, or a state of transition and transformation, as a reflection and response to chronic societal stressors. Liminality is further described as a concept that has traditionally encompassed a 'rite of passage', where the initiated are separated from society and brought to a space outside of the community, with new rules, in preparation for rejoining society as fully-fledged adult members (Turner, 1967, as cited in Eli, 2018). Thus, liminality represents an in-between state of safety and indefinite time and space where EDs/DE functions to surpass coping with negative affect and offers a mode of becoming different, special, separated and disconnected from painful life circumstances (Eli, 2018). In liminality, EDs/DE operates as an attempt to adaptively cope with but also transcend one's environment, and it can be contextualized within a social, relational, and existential framework.

The participants in Eli's study (2018), 35 Israeli women and 1 Israeli man, who by living in a country in transition had experienced chronic war/civil conflict stress, embodied liminality by pulling inward and away from their interpersonal relationships. One woman described her embodiment of restricted eating and hunger as allowing her to relate to others from a position of disconnection yet strength. By contrast, binge eating for some study participants conveyed an ambivalent mixture of feeling rejection by others but also pride in the form of rebellious authenticity experienced through binge behaviors. Furthermore, binges were described as lifesaving and a reclamation of the self that was silenced through both societal and dietary restriction and hence imbued with existential shame. Another participant struggling with AN

explained the role of liminality in her ED as a way to satisfy the need to go through a dying process, and presumably a transformative rebirth, without actually facing the finality of death.

Refugee and immigrant journeys incorporate deeply layered transitions that can also be viewed through a liminal lens. The liminal aspects of these journeys embody a striving for safety, sense of control, belongingness, meaning-making, reconciliation of traumatic phenomena, and resettlement in a new world. Among refugees' and immigrants' experiences of humiliation/shame and guilt, daily stressors and burdens, and role changes can trigger ED/DE behaviors and induce liminal states that point to the desire for transcendence and comfort, self-control, purposefulness, and social acceptance.

Food (In)Security, Shortage, and Restriction

Food security signifies people having sufficient access to appropriate, nutritious, and safe food that allows them to meet both dietary as well as quality of life needs. By contrast, food insecurity refers to contexts where there is insufficient access to such food (Becker, Middlemass, Johnson, Taylor, Gomez, & Sutherland, 2018). The chronic stresses of war and civil conflict can lead to disruption in food supply, which can then trigger unstructured eating behaviors and forced dieting that contribute to increased risk of developing EDs/DE. Furthermore, altered food patterns that include changes in meal size, frequency, and food diversity appear to be associated with an increased risk of EDs/DE (Goldschmidt, 2008, as cited in Aoun, Garcia, Mounzer, Hlais, Grigioni, Honein, & Déchelotte, 2013). Maharaj et al. (2017) found a high prevalence of food insecurity among a group of immigrants and refugees in South Africa, which impacted their mental health status by contributing to an increase in depression and anxiety symptoms. Other studies have found evidence for the relationship between food insecurity and mental health

issues within conflict-affected and internally-displaced populations in low- and middle-income countries, such as Uganda (Mugisha et al., 2015, as cited in Maharaj et al., 2017) and Sri Lanka (Siriwardhana et al., 2013, as cited in Maharaj et al., 2017).

Food insecurity in urban U.S. households also poses significant risk factors for EDs/DE. These households often simultaneously have limited access to affordable, nutritious food (Dutko, 2012; Kato & Irvin, 2013, as cited in Becker, Middlemass, Gomez, & Martinez-Abrego, 2019) and abundant access to inexpensive and highly processed food, which in animal-model research, was implicated in the development of binge eating (Becker, Middlemass, Gomez, & Martinez-Abrego, 2019). In one U.S. study, participants with the highest level of food insecurity, who were adults reporting having hungry children in their household, endorsed significantly higher levels of EDs/DE pathology, binge eating, dietary restraint, weight stigma, and worry compared to participants with lower levels of food insecurity. Compensatory behaviors, such as vomiting, laxative/diuretic use, skipping meals, and exercise also increased as the level of food insecurity worsened (Becker, Middlemass, Taylor, Johnson, & Gomez, 2017).

Another study of food insecure urban U.S. households found restricting for weight and shape reasons was rarely reported and restricting intake to make food last, saving food for children, or not having enough resources to buy sufficient food was instead endorsed; however, this dietary restraint still correlated with EDs/DE pathology (Becker, Middlemass, Gomez, & Martinez-Abrego, 2019). Findings from this study highlight the need for additional psychological research to integrate focus on marginalized populations and address disparities in their experiences of food access and healthcare and to move past the stereotypical portrait of who is/is not at risk for developing EDs/DE. Equally significant, Becker et al. (2019) presented reports that suggest those who differ from the EDs/DE stereotype of thin, White, affluent, and

female, are less likely to think they have EDs/DE or perceive a need for treatment (Becker, Middlemass, Gomez, & Martinez-Abrego, 2019).

Finally, Becker, Middlemass, Johnson, Taylor, Gomez, & Sutherland (2018) found traumatic event exposure in a low-income marginalized population of Latinas in the U.S. was associated with higher levels of food insecurity and EDs/DE pathology, particularly binge-purge behaviors, including vomiting and laxative/diuretics use. Individuals in this study who either directly experienced a traumatic event or witnessed one showed higher levels of food insecurity associated with greater traumatic event exposure. Increased exposure to traumatic events correlated with worsened overall EDs/DE pathology, weight stigma, and anxiety. According to Becker et al. (2018), their results indicated the dire need for further research given that traumatic event exposure, EDs/DE pathology, weight stigma, and anxiety may complicate effective delivery of public health interventions in those living with food insecurity in the U.S. and around the world.

Screening & Assessment

Many refugees and immigrants arriving in the U.S. come from countries where Western-based mental health services are uncommon and often stigmatized, and, therefore, individuals are more likely to be referred for a mental health consultation from a primary healthcare provider (Brown, 2008). This may be particularly significant for assessing EDs/DE as there are both physical and psychological components at play. Ritchie et al. (2006) found that stigma and distrust also play significant roles in healthcare access for non-White U.S. minorities. They are less likely than Whites to seek treatment from mental health clinicians and typically present for

treatment when symptoms are more severe. Additionally, individual and cultural understandings of what medically is considered distressing or impairing have bearing on symptom reporting that could influence detection and diagnosis.

The CDC (2012) acknowledged the need for comprehensive physical and mental health assessment for refugees and immigrants pre-resettlement in the U.S. and recognized that individuals from these groups may not readily volunteer symptoms at initial screening. Bögner et al. (2010) found that refugees with a history of sexual violence reported more difficulties in disclosing personal information. They also were more likely to dissociate during initial interviews and scored significantly higher on PTSD and shame measures than those without a sexual violence history. Furthermore, since mental health symptoms, including EDs/DE behaviors, may emerge several months or years after resettlement, follow-up and/or on-going care with culturally-informed mental health clinicians is essential in refugee and immigrant healthcare.

Evidence-based screeners, assessments, and treatments for EDs/DE have been primarily developed and tested in White populations (Reyes-Rodriguez & Bulik, 2010, as cited in Anderson et al., 2018), which poses problems for mental health clinicians trying to adhere to evidence-based protocols. Cultural values are imbedded in psychological test, assessment, and treatment content and procedures, and, consequently, must be included in the design of assessment instruments for diverse populations (Le Grange et al., 2004). Clinicians have to consider whether to adopt, adapt, or abandon traditionally researched EDs/DE instruments. For example, they can consider adapting researched interventions when they believe the treatment has utility but may not be wholly appropriate for that particular individual's issue and context. However, without consistent, long-term research, the downside of this approach is the unknown

impact any adaptations would have on screening and/or treatment efficacy, therefore, frequent and diligent consultation between client and clinician would be paramount (Morales & Norcross, 2010, as cited in Anderson, 2018).

Currently, none of the screeners used in refugee and immigrant healthcare, including the Refugee Health Screener 13 (RHS-13), incorporate any EDs/DE assessment. There are customized in-house as well as a few standard screeners used in general EDs/DE assessment, such as the EDI-3 (Eating Disorder Inventory-3), SCOFF Questionnaire (Sick Control One Fat Food), EDE (Eating Disorder Examination), and EDE-Q (Questionnaire). Becker, Middlemass, Gomez, & Martinez-Abrego (2019) assert that more accurate clinical information may be gleaned from interview-based assessment instruments than from self-report measures, which are often required when conducting unfunded research in a novel area but may lead to inflated symptom reporting. When screening for EDs/DE, it may be beneficial to discuss self-report measures with refugee and immigrant clients beforehand and implement interview follow-ups. For instance, EDs/DE screening tools that allow for explanation of behaviors should be used, together with cognizance and flexibility in assessing EDs/DE symptomology that may deviate from current diagnostic criteria included in the DSM-V (Anderson, et al., 2018).

Additionally, non-gender-specific EDs/DE assessment and screening should also be implemented. Men represent up to 25-36% of individuals with any lifetime eating disorder (Hudson et al., 2007; Kjelsas et al., 2004, Madden, Morris, Zurynski, Kohn, & Elliot, 2009; Woodside et al., 2001, as cited in Anderson, 2018), and some researchers have speculated that there may be increasing prevalence of eating disorders among males in recent years, although there are no current consistent trends in the rates of diagnoses. Research indicates, however, that DE behaviors (e.g., extreme dieting, purging) have increased at a faster rate in the past decade

for males over females (Mitchison, Mond, Slewa-Younan, Hay, 2013, as cited in Anderson, 2018).

Healthcare provider collaboration and consultation around shared perceptions of EDs/DE behaviors in any particular refugee or immigrant community is a crucial component of assessment and screening. EDs/DE researchers are often psychologists and psychiatrists who would benefit from employing interdisciplinary approaches in order to render cross-cultural research efforts more successful (Nasser et al., 2001, as cited in Le Grange et al., 2004), including consulting with medical anthropologists when necessary. Holding an understanding of stressors specific to any given community and being curious about concerning eating or feeding behaviors, not only as perceived by the individual but how they may be experienced and impacting the family or community, is also required for clinically responsible assessment and screening. Ultimately, providing clinical transparency, employing appropriate and tailored psychoeducation, and learning about the culture of the family and community of the unique individual being treated, aids in the creation of culturally-responsive healthcare screening and assessment.

Supplemental EDs/DE Assessment Questions

Screening and tools such as "Kleinman's 8 Questions" ***(see Appendix A)*** and the American Psychological Association's (APA) Cultural Formulation Interview (CFI) ***(see Appendix B)*** seek to validate and introduce into the clinical assessment process both an individual's values as well as their unique cultural ones. These instruments can be consulted to achieve more intercultural competence in screening for EDs/DE in refugee and immigrant populations. Additionally, they may be used to supplement, modify, and/or adapt standard

EDs/DE screeners. Drawing from their examples, the following are some potential interview question considerations for screening EDs/DE in refugee and immigrant populations. If applicable, each question can be followed up with further clinical curiosity and exploration.

- ⇒ What are some things in your life now you have control over?
    - What about in the past?
- ⇒ What are some things in your life now you do not have control over?
    - What about in the past?
- ⇒ How do you take care of yourself when you feel worried/nervous/sad/scared?
- ⇒ How are you taken care of when you feel/worried/nervous/sad/scared?
- ⇒ What were your eating habits/behaviors like before you left your home/country?
- ⇒ What were your eating habits/behaviors like in-between leaving your home/country and arriving here?
- ⇒ What are your current eating habits/behaviors like?
- ⇒ How do you feel about food and eating?
- ⇒ Do you think/feel/believe you have a problem(s) with food or eating?
    - If so, what do you think/feel/believe caused this problem(s)?
        - When did the problem begin?
            - How long do you think it will last?
                - How will it/you get better?
- ⇒ Do you know anyone who shares similar thoughts/feelings/beliefs about food or eating?
- ⇒ Do you know anyone who has different thoughts/feelings/beliefs about food or eating from yours?

- ⇒ Do you have any rules/rituals/beliefs/fears about food or eating?
- ⇒ Do you know anyone who has any rules/rituals/beliefs/fears about food or eating?
- ⇒ How often do you think about food and eating?
- ⇒ Do you ever feel guilty or ashamed about food and eating?
- ⇒ What do you think would be helpful to you?

Treatment

Relationality has been a focus in cultural anthropology. In anthropological research, EDs/DE conceptualizations encompass the synergy between people, which is mediated through everyday activities that foster a spectrum of connection and disconnection, such as eating, living together, and sharing emotion (Eli & Warin, 2018). Anthropologists have examined how some people with EDs/DE are drawn toward meaning-making of their diagnostic labels and often form strong communities of belonging, both online and in treatment settings, whereby growing attached to their disorder through the meaningful social relationships it facilitates (Eli, 2014a; Lavis, 2011; Warin, 2010, as cited in Eli & Warin, 2018). Thus, rather than position patients with EDs/DE as simply isolated individuals suffering from an illness, anthropological research has delineated the bonds they form with themselves and their fellow patients, through these altered relationships, as constituting powerful forms of relatedness that may impact treatment (Eli & Warin, 2018). According to Lester (2018), clinicians believed their affective and interpersonal engagements with clients were just as significant for successful treatment as was observing ED/DE behaviors or measuring changes in weight or lab results.

Miller & Rasco (2004) present an ecological paradigm of community psychology, which empathizes multidisciplinary collaboration and community empowerment in the treatment of refugee and immigrant mental health. An ecological approach serves as a means to balance interventions between the individual's needs and their role in the community. A fundamental principle of this approach is that psychological problems often reflect the disparity between an individual's environmental demands and the adaptive resources to which they have access. Consequently, ecological interventions seek to alter and/or create contexts that are more conducive to individuals' needs and capacities as well as enhance their capacity to effectively adapt to their existing settings. Another important ecological principle is to prioritize prevention efforts as they are generally more effective, cost-efficient, and humane than exclusively relying on the treatment of problems once they have developed (Miller & Rasco, 2004). Therefore, prioritizing and utilizing culturally-responsive EDs/DE screeners, or at the very least supplemental EDs/DE assessment questions, would contribute significantly to preventative efforts in the early clinical intervention stages with refugee and immigrant populations. Aoun, Joundi, & El Gerges (2019) agree that there is currently no standardized screening and assessment for EDs/DE for refugee populations, and we may be missing opportunities to detect and then treat these harmful and potentially fatal disorders. Therefore, it is necessary for mental health clinicians to consider the possibility of EDs/DE in screening, assessment, and case formulation for treatment planning with refugees and immigrants coping with impactful transitions and daily stressors. As an example, a positive screen for PTSD could trigger a screening and assessment for EDs/DE.

Considerations regarding disruptions in attachment to self and others are also necessary in treatment with refugees and immigrants who present with co-morbid stressor-related and

ED/DE behaviors. According to Piran (2017), the Experience of Embodiment (EE) construct in working with EDs/DE captures the quality of embodied experiences along five dimensions: body connection and comfort, agency and functionality, experience and expression of desire, attuned self-care, and subjective immersion in inhabiting the body/resisting objectification. The clinical recommendation is to employ therapeutic approaches that target the underlying experiences of body disconnection instead of focusing exclusively on specific behavioral disruptions. Mental health clinicians can help refugees and immigrants struggling with EDs/DE and relational issues re-define their personal narratives by exploring how their food attitudes, beliefs, and behaviors have been affected through their interpersonal transition processes.

Rieger et al. (2010) discussed an EDs/DE-specific model of interpersonal psychotherapy (IPT) that incorporates a focus on attachment in the therapeutic process. An IPT intervention approach uses a full chronological review of an individual's significant life events, including mood and self-esteem patterns and interpersonal relationships, in order to identify areas potentially associated with the development and maintenance of psychological symptoms (Wilfley et al., 2000; Wilfley et al., 2003, as cited in Rieger et al., 2010). In IPT for EDs/DE (IPT-ED) (Jacobs et al., 2004; Tanofsky-Kraff & Wilfley, in press, as cited in Rieger et al., 2010), specific problem areas are identified and their impact on ED/DE behaviors are investigated. For instance, a grief problem area is identified as a focus of treatment when ED/DE behaviors are associated with the loss of a relationship, and a role transition problem area is identified when ED/DE behaviors are associated with a change in life status or circumstance.

IPT-ED draws upon traditional conceptualizations of EDs/DE that ascribe a pivotal role to self and identity issues in the development and maintenance of ED/DE behaviors; however, it adds to these conceptualizations the links between the individual’s personal issues and their

experiences and perceptions of their social world. The premise being that disturbances of self can trigger and maintain EDs/DE and arise as a result of inadequacies in an individual's interpersonal relationships in their social world (Rieger et al., 2010). Finally, clinical interventions for EDs/DE in refugee and immigrant populations must in addition consider how intersectional issues impact individual treatment goals and outcomes.

Closing Remarks

The intention of this paper is to inform mental health clinicians and humanitarian organizations of the imperative of screening for EDs/DE in refugee and immigrant populations. Refugees and immigrants have unique mental health needs that impact successful holistic healthcare. Experiences of potential historic home country challenges along with prevailing changes and adjustments can produce psychologically destabilizing circumstances that often include unpredictable living environments, new daily routines and stressors, and issues involving losses of control. The current dearth of conversation, debate, research, screening & assessment, and intervention regarding EDs/DE in these communities not only exposes a service gap, it also reveals a health disparity and a plausible implicit bias that surrounds detection and intervention for EDs/DE in non-traditional populations. Awareness of how mental health issues in general are perceived and handled within the construct of viewing certain groups as 'other' is key. Furthermore, it is necessary to study transformations in food and eating attitudes, beliefs, and behaviors in refugee and immigrant communities separately from solely focusing on differences in new food and eating choices.

Mental health clinicians and humanitarian organizations working with refugees and immigrants may build upon and broaden their culturally-alert practices by incorporating conscientious and efficacious EDs/DE screening to bolster assessment and inform intervention. Relational approaches to understanding and treating EDs/DE in refugee and immigrant populations would be beneficial as they highlight individual experiences, contextualize them, and promote treatment within an attuned and mutually created therapeutic relationship. Treatment considerations in refugees' and immigrants' diverse experiences of transition and resettlement should integrate individual, cultural, and environmental factors, including the impact of any accompanying ED/DE behaviors, toward the goal of increasing their psychosocial wellness.

Appendix A

Kleinman's Eight Questions

Psychiatrist and anthropologist Arthur Kleinman's theory of explanatory models (EMs) proposes that individuals and groups can have vastly different notions of health and disease. Kleinman proposed that instead of simply asking patients, "Where does it hurt," the physicians should focus on eliciting the patient's answers to "Why," "When," "How," and "What Next."

Kleinman suggests the following questions to learn how your patient sees his or her illness:

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

Namratha Kandula, MD. "The Patient Explanatory Model." The HealthCare Blog, June 11, 2013
http://thehealthcareblog.com/blog/2013/06/11/the-patient-explanatory-model/

Appendix B

Cultural Formulation Interview (CFI)—Informant Version

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INFORMANT:* I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.
RELATIONSHIP WITH THE PATIENT	
Clarify the informant's relationship with the individual and/or the individual's family.	1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? *PROBE IF NOT CLEAR:* How often do you see [INDIVIDUAL]?
CULTURAL DEFINITION OF THE PROBLEM	
Elicit the informant's view of core problems and key concerns. *Focus on the informant's way of understanding the individual's problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son").*	2. What brings your family member/friend here today? *IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would ***you*** describe [INDIVIDUAL'S] problem?
Ask how informant frames the problem for members of the social network.	3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would ***you*** describe [INDIVIDUAL'S] problem to them?
Focus on the aspects of the problem that matter most to the informant.	4. What troubles you most about [INDIVIDUAL'S] problem?
CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT	
	CAUSES
This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. *Note that informants may identify multiple causes depending on the facet of the problem they are considering.*	5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.	6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?

Cultural Formulation Interview (CFI)—Informant Version

STRESSORS AND SUPPORTS	
Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?
ROLE OF CULTURAL IDENTITY	
	Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.
Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.	9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her?
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING	
SELF-COPING	
Clarify individual's self-coping for the -problem.	12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [-PROBLEM]?
PAST HELP SEEKING	
Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing). *Probe as needed (e.g., "What other sources of help has he/she used?").* *Clarify the individual's experience and regard for previous help.*	13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

BARRIERS	
Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background?
CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING	
PREFERENCES	
Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant. *Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?").* *Focus on the views of the social network regarding help seeking.*	Now let's talk about the help [INDIVIDUAL] needs. 15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]? 16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now?
CLINICIAN-PATIENT RELATIONSHIP	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

References

Alegria, M., Woo, M., Cao, Z., Torres, M., Meng, X., & Striegel-Moore, R. (2007). Prevalence and Correlates of Eating Disorders in Latinos in the U.S. *The International Journal of Eating Disorders, 40*(Suppl), S15-S21.

Anderson, L. K., Murray, S. B., & Kaye, W. H. (2018). *Clinical Handbook of Complex and Atypical Eating Disorders.* Oxford University Press.

Andrews, R. (2015). All about disordered eating: Understanding and addressing eating disorders. *Precision Nutrition*, 11–21. Retrieved from https://www.precisionnutrition.com/all-about-disordered-eating

Aoun, A., Garcia, F., Mounzer, C., Hlais, S., Grigioni, S., Honein, K., & Déchelotte, P. (2013). *War stress may be another risk factor for eating disorders in civilians: A study in Lebanese University Students*. *35*(4), 393–397. https://doi.org/10.1016/j.genhosppsych.2013.02.007

Aoun, A., Joundi, J., & El Gerges, N. (2019). Prevalence and correlates of a positive screen for eating disorders among Syrian refugees. *European Eating Disorders Review,27*(3), 263-273.

BBC News. (2000, July 5). *Anorexia found in rural Africa*. Retrieved from http://news.bbc.co.uk/2/hi/health/818725.stm

Becker, A. E., Fay, K., Agnew-Blais, J., Guarnaccia, P. M., Striegel-Moore, R. H., & Gilman, S. E. (2010). Development of a Measure of "Acculturation" for Ethnic Fijians: Methodologic and Conceptual Considerations for Application to Eating Disorders Research. *Transcultural Psychiatry,* 47(5), 754-788.

Becker, C. B., Middlemass, K. M., Gomez, F., & Martinez-Abrego, A. (2019). Eating Disorder Pathology Among Individuals Living with Food Insecurity: A Replication Study. *Clinical Psychological Science, 7*(5), 1144-1158.

Becker, C. B., Middlemass, K., Johnson, C., Taylor, B., Gomez, F., & Sutherland, A. (2018). Traumatic event exposure associated with increased food insecurity and eating disorder pathology. *Public Health Nutrition, 21*(16), 3058-3066.

Becker, C. B., Middlemass, K., Taylor, B., Johnson, C., & Gomez, F. (2017). Food insecurity and eating disorder pathology. *The International Journal of Eating Disorders, 50*(9), 1031-1040.

Bolton, E.E. (2019, October 14). *PTSD: National Center for PTSD, PTSD In Refugees*. U.S. Department of Veterans Affairs. Retrieved from https://www.ptsd.va.gov/professional/treat/specific/ptsd_refugee.asp

Bögner, D., Brewin, C., & Herlihy, J. (2010). Refugees' Experiences of Home Office Interviews: A Qualitative Study on the Disclosure of Sensitive Personal Information. *Journal of Ethnic and Migration Studies, 36*(3), 519-535.

Boston Children's Hospital. (n.d.). *Refugee and Immigrant Core Stressors Toolkit.* Retrieved from https://redcap.tch.harvard.edu/redcap_edc/surveys/index.php?s=HRPDCPPA3H

Brown, L. S. (2008). *Cultural Competence in Trauma Therapy: Beyond the Flashback.* American Psychological Association.

Budiman, A., Tamir, C., Mora, L., & Noe-Bustamante, L. (2018, August 20). *Facts on U.S. immigrants, 2018: Statistical portrait of the foreign-born population in the United States Pew Center*. Retrieved from https://www.pewresearch.org/hispanic/2020/08/20/facts-on-u-s-immigrants/

Causadias, J. M., Vitriol, J. A., & Atkin, A. L. (2018). The cultural (mis)attribution bias in developmental psychology in the United States. *Journal of Applied Developmental Psychology, 59*, 65-74.

Centers for Disease Control and Prevention (CDC). (2012, March 29). *Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees*. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

Chesler, B. E. (2005). Implications of the Holocaust for eating and weight problems among survivors' offspring: An exploratory study. *European Eating Disorders Review, 13*(1), 38-47.

Claudat, K., White, E. K, & Warren, C. S. (2016). Acculturative Stress, Self-Esteem, and Eating Pathology in Latina and Asian American Female College Students. *Journal of Clinical Psychology, 72*(1), 88-100.

Di Nicola, V. (2020). Antonella: 'A Stranger in the Family'—A Case Study of Eating Disorders Across Cultures. In Stoyanov, D., Fulford, B., Stanghellini, G., Van Staden, W., Wong, M. T. H. (2021), *International Perspectives in Values-Based Mental Health Practice: Case Studies and Commentaries* (pp. 27-35). Springer.

Eli, K. (2018). Latin American countries lead in Google search volumes for anorexia nervosa and bulimia nervosa: Implications for global mental health research. *The International Journal of Eating Disorders,* 51(12), 1352-1356.

Eli, K. (2018). Striving for liminality: Eating disorders and social suffering. *Transcultural Psychiatry, 55*(4), 475-494.

Eli, K., & Warin, M. (2018). Anthropological Perspectives on Eating Disorders: Deciphering Cultural Logics. *Transcultural Psychiatry, 55*(4), 443-453.

Engel, B., & Patricelli, K. (n.d.). *Eating Disorders: Causes of Eating Disorders—Biological Factors* [Gulf Bend Center]. Retrieved from https://www.gulfbend.org/poc/view_doc.php?type=doc&id=11748&cn=46

Frank, G. K. W. (2016). *What Causes Eating Disorders – And What Do They Cause? An Essential Introduction for Anyone Who Would Like to Understand Eating Disorders and How to Overcome Them.* BookLocker.com, Inc.

Latzer, Y., Witztum, E., & Stein, D. (2008). Eating Disorders and Disordered Eating in Israel: An Updated Review. *European Eating Disorders Review*, *16*, 361–374. https://doi.org/10.1002/erv.875

Le Grange, D., Loux, J., Breen, A., & Katzman, M. A. (2004). The Meaning of "Self-Starvation" in Impoverished Black Adolescents in South Africa. *Culture, Medicine and Psychiatry*, *28*, 439–461. https://doi.org/10.1007/s11013-004-1064-8

Lester, R. J. (2018). Ground zero: Ontology, recognition, and the elusiveness of care in American eating disorders treatment. Transcultural Psychiatry, 55(4), 516-533.

Maharaj, V., Tomita, A., Thela, L., Mhlongo, M., & Burns, J. K. (2017). Food Insecurity and Risk of Depression Among Refugees and Immigrants in South Africa. *Journal of Immigrant and Minority Health, 19*(3), 631-637.

Maychick, D. (1996). *Audrey Hepburn: An intimate Portrait*. Citadel Press.

Miller, E. M., & Rasco, L. M. (2004). *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*. Lawrence Erlbaum Associates, Inc.

Mollica, R. F. (2006). *Healing Invisible Wounds: Path to Hope and Recovery in a Violent World*. Vanderbilt University Press.

Nyirabihogo, N. (2014, December 3). In Rwanda, New Idealization of Thinness Coincides With Rise in Eating Disorders, Educators Say. *Global Press Journal*. Retrieved from https://globalpressjournal.com/africa/rwanda/in-rwanda-new-idealization-of-thinness-coincides-with-rise-in-eating-disorders-educators-say/

Pappas, S. (2019, June). Treating Women and Girls in Context. *Monitor on Psychology*.

Patil, C. L., McGown, M., Nahayo, P. D., & Hadley, C. (2010). Forced Migration: Complexities in Food and Health for Refugees Resettled in the United States. *NAPA Bulletin, 34*(1), 141-160.

Pike, K. M., & Dunne, P. E. (2015). The rise of eating disorders in Asia: A review. *Journal of Eating Disorders*, *3*(33). https://doi.org/10.1186/s40337-015-0070-2

Piran, N. (2017). *Journeys of Embodiment at the Intersection of Bodies and Culture*. Academic Press.

Refugee Health Technical Assistance Center. (2011). *Assessments for Trauma and Mental Health in Refugees*. Retrieved from https://refugeehealthta.org/physical-mental-health/mental-health/adult-mental-health/assessments-for-trauma-and-mental-health-in-refugees/

Rieger, E., Van Buren, D. J., Bishop, M., Tanofsky-Kraff, M., Welch, R., & Wilfley, D. E. (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment implications. *Clinical Psychology Review, 30*(4), 400-410.

Ritchie, E. C., Watson, P. J., & Friedman, M. J. (2006). *Interventions Following Mass Violence and Disasters*. The Guilford Press.

Ross, W. L., Gallego-Pérez, D. F., Lartey, A., Sandow, A., Pérez-Escamilla, R., & Hromi-Fiedler, A. (2017). Dietary patterns in Liberian refugees in Buduburam, Ghana. *Maternal and Child Nutrition, 13*(4), N/a.

Saccone, B. H., & Obeng, C. S. (2015). Food choices and eating patterns of international students in the united states: A phenomenological study. *International Public Health Journal, 7*(4), 357-361. Retrieved from https://du.idm.oclc.org/login?url=https://www-proquest-com.du.idm.oclc.org/scholarly-journals/food-choices-eating-patterns-international/docview/1752118474/se-2?accountid=14608

Šerifović, Š., Dinnel, D. L., & Sinanović, O. (2005). Body Dissatisfaction: How Is It Related to Stress and One's Perception of Individual and Cultural Ideal Body? A Comparison of Bosnian and American University Students. *Bosnian Journal of Basic Medical Sciences*, *5*(1), 27–33.

Simmons. (2002, January 13). Eating Disorders on Rise for South African Blacks. *Los Angeles Times*. Retrieved from https://www.latimes.com/archives/la-xpm-2002-jan-13-mn-22314-story.html

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Understanding the Impact of Trauma. In *Trauma-Informed Care in Behavioral Health Services*. Center for Substance Abuse Treatment (US).

Swanson, S. A., Saito, N., Borges, G., Benjet, C., Aguilar-Gaxiola, S., Medina-Mora, M. E., & Breslau, J. (2011). Change in binge eating and binge eating disorder associated with migration from Mexico to the US. *Journal of Psychiatric Research, 46*(1), 31-37.

Troop, N. A., Allan, S., Serpell, L., & Treasure, J. L. (2008). Shame in women with a history of eating disorders. *European Eating Disorders Review, 16*(6), 480-488.

United Nations High Commissioner for Refugees (UNHCR). (n.d.). *Refugees Data Finder*. Retrieved from https://www.unhcr.org/refugee-statistics/

United Nations High Commissioner for Refugees (UNHCR). (n.d.). *Refugees in America*. Retrieved from https://www.unrefugees.org

United Nations High Commissioner for Refugees (UNHCR). (n.d.). *Global Impact of Our Donors*. Retrieved from https://www.unrefugees.org/refugee-facts/usa/

Verza, M. (2021, February 24). *Asylum seekers rush to register for US border processing*. AP News.

Williams, C. L., & Berry, J. W. (1991). Primary Prevention of Acculturative Stress Among Refugees. *The American Psychologist*, *46*(6), 632–641.