A VOLUME IN
AN INTERSECTIONAL APPROACH TO COUNSELING AND HEALTH

COUNSELING INDIVIDUALS WITH EATING DISORDERS

AN INTERSECTIONAL APPROACH

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Counseling Individuals With Eating Disorders

An Intersectional Approach

A Volume in An Intersectional Approach to Counseling and Health

Series Editors

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An Intersectional Approach to Counseling and Health

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PREFACE

Jennie Park-Taylor,
Merle A. Keitel, and Melinda Parisi Cummings

Counseling Individuals With Eating Disorders: An Intersectional Approach was written to provide mental health professionals and students of counseling, medicine, psychology, social work, nursing, and other helping professions with useful information and suggestions for their work with individuals with eating disorders. The chapter authors rely on an intersectional understanding of the human experience and specifically focus on how individuals with various intersecting identities experience, understand, and seek support for their disorders. We are so grateful to the diverse group of authors who collectively contributed their professional expertise to create this culturally-centered, engaging, and interdisciplinary resource. We strongly believe that our book fills a unique gap in the currently available texts that address these issues because case examples are included that are embedded in a specific sociocultural context. It is important to note that, although a range of illnesses are represented, the book is not comprehensive. The chapters that we did include, however, represent eating disorders that are frequently encountered in clinical settings and each chapter has great practical significance and utility for mental health practitioners as well as students in training.

Throughout the book, there is a strong emphasis on Crenshaw's (1989) conception of intersectionality as a way to better understand the dynamic relationships between societal and individually-based drivers of health behaviors and outcomes. Crenshaw's work in the early 1990s that explored

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Black women's compounding experiences of discrimination in the United States served as foundational for her articulation of the concept of intersectionality, which describes how systems of oppression overlap to create distinct experiences for people based on their multiple identity categories. Considering contemporary research that has outlined some of the ways in which individuals' multiple social identities interconnect and interact to compound experiences of illness, health psychology researchers would benefit from applying an intersectional understanding of health in their explorations of the micro- and macro-level variables that influence pathways towards health and illness for different groups (Heard et al., 2020). For mental health practitioners, an intersectional lens will more likely lead to innovative and inclusive interventions. Furthermore, an intersectional approach to treating individuals with eating disorders requires that helping professionals are aware of, attuned to, and skilled at addressing their diverse clients' multiple experiences of oppression. This is critical given that social ills (e.g., racism, ageism, gender discrimination, religious discrimination) can and are experienced together, produce material and social disadvantage, and serve to maintain health disparities (Heard et al., 2020; McGibbon & McPherson, 2011).

Counseling Individuals With Eating Disorders: An Intersectional Approach includes chapters that focus on general topics, such as intersectionality and ethics, counseling individuals with specific eating disorders, counseling special populations, and counseling parents. Each of the disorder-specific chapters in the book begins with a description of the disorder, research regarding prevalence rates across diverse groups, and evidence-based treatments. Most chapters include an extended case vignette that highlights considerations relevant to a client's intersectional identity, followed by an analysis of the vignette from the perspective of a theoretical approach or approaches supported by empirical research. Chapters conclude with future directions for treatment, research, theory, and policy, as well as four to five questions for discussion.

Of course, meaningful differences exist within various cultures, and we recognize that the way authors have conceptualized diverse groups may not apply to all individuals in those groups. Given page limitations, we were unable to include all groups or examples of clients with all intersecting identities. That said, we are confident that our book is an initial step toward acknowledging the importance of considering intersectionality in clinical work and will be of great use to mental health practitioners and students who plan to or are currently working with individuals with eating disorders. Readers of the book can focus on a specific eating disorder and develop their knowledge, skills, and awareness of cultural and systemic considerations.

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CHAPTER 1

INTERSECTIONALITY AND EATING DISORDERS

Natasha L. Burke, Julia Yermash,
Tatyana Bidopia, and Yvette Karvay

The exact term "intersectionality" is credited to Kimberlé Crenshaw, a United States civil rights advocate and critical race theorist (Crenshaw, 1993). Though some erroneously consider this the beginning of intersectionality, it was only the introduction of the term, which also spurred discourse in the academic realm (Collins & Bilge, 2020). Though there are myriad ways scholars, practitioners, and activists may define intersectionality, the following definition captures the intricacies of the construct:

> Intersectionality investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytic tool, intersectionality views categories of race, class, gender, sexuality, class [*sic*], nation, ability, ethnicity, and age—among others—as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining complexity in the world, in people, and in human experiences. (Collins & Bilge, 2020, p. 2)

As such, intersectionality acknowledges mutually dependent social categories operating within the context of larger political, economic, and cultural structures that differentially predict experiences and outcomes. Importantly, the ethos of intersectionality involves social justice advocacy.

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Intersectionality has existed—even if not named as such—since at least the 19th century. Examples of intersectionality at work in the 1800s include Savitribai and Jyotirao Phule's political activism in India confronting casteism, classism, sexism, and religious inequalities and Sojourner Truth's civil and women's rights activism confronting slavery at the crossroads of race and sex in the United States (Collins & Bilge, 2020).

In the United States, it was the activism of Black feminists in the 1960s and 1970s, and the scholarship and activism of critical race theorists, that brought the ethos of intersectionality into the broader social discourse (e.g., Beale, 1970; Crenshaw, 1993; Hill Collins, 1990). During the 1960s and 1970s feminist movement in the United States, Black women felt they were not adequately represented. Indeed, the historical, political, and economic policies of the United States resulted in unique—and often oppressive and detrimental—experiences for Black women that had not been addressed in the prevailing feminist rhetoric. Black feminists called for changes in that discourse, arguing that their multiple social identities (e.g., race and gender) operated both independently and interactively to determine their risk of discrimination, disadvantage, and disparity (Cole, 2009).

Intersectionality recognizes that an individual's interlocking aspects of identity operates within existing systems of power, privilege, and oppression that differentially influence and predict one's experiences and outcomes. Categories of identity are, in large part, determined by the social structures that create and house them. Additionally, individuals present to the world as one entity—not individual aspects of identity (e.g., gender, race, class, etc.)—and these socially-constructed identities and the power differentials that create them are mutually dependent and impact daily life. Therefore, Black feminists advocated for their voices to be heard, which meant society's recognition that their race and their gender together (i.e., the distinctive aspects of being a Black woman) resulted in unique and compounding experiences of discrimination, disadvantage, and disparities not fully accounted for by their race only (i.e., being Black) or their gender only (i.e., being a woman). Each social category afforded its own "-ism"—racism and sexism—that, when combined for Black women, were more detrimental than the sum of their parts. Though considerations of intersectionality historically occur within the context of social justice and advocacy, intersectionality acknowledges privilege and power, in addition to oppression. As such, it could equally help in considering how some in a given population may be disproportionally *advantaged* for various outcomes and opportunities within a given sociocultural context, depending on the combination of their various identities, though this focus is more readily used as a benchmark highlighting disparities for other, relatively disadvantaged, groups.

Intersectionality's Relevance for Mental Health

A prerequisite to adequate mental health treatment inherently includes understanding the complexity of people, human nature, and the human experience. As such, governing professional organizations in the fields of psychology, medicine, and social work have issued guidelines emphasizing the importance of a taking a multicultural stance to improve our understanding of how sociocultural context influences the human experience and mental health (Clauss-Ehlers et al., 2019; National Association of Social Workers, 2015; U.S. Department of Health and Human Services Office of Minority Health, 2016). The American Psychological Association's *Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century* pinpointed intersectionality as the most important guideline for multicultural psychological treatment (Clauss-Ehlers et al., 2019). Though each of the guidelines harken to intersectionality-informed practices, Guidelines 1, 5, and 8 from the *Multicultural Guidelines* are particularly salient.

> **Guideline 1.** Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic.

To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts. (American Psychological Association, 2017, p. 4)

Though identity is often implicitly conceptualized as static (Derlan Williams et al., 2020), it is fluid across social contexts and across the life course. Importantly, how one is perceived by others versus how one perceives themselves is just as complex and can similarly change across social contexts and throughout development. As a result, as the guideline implies, how our clients present to treatment, how we perceive them presenting to treatment, and our case conceptualization are all influenced by our own social contexts and identities. Accordingly, as clinicians, we need to be aware of and actively address our potential blind spots in the assessment and treatment context.

> **Guideline 5.** Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services. (American Psychological Association, 2017, p. 4)

> **Guideline 8.** Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity. (American Psychological Association, 2017, p. 5)

The crux of intersectionality and mental health is contained in these two guidelines. Intersectionality-informed approaches help clarify and address culturally relevant social categories that confer risk (or protection) secondary to systemic, structural, and individual factors. Such approaches allow for understanding the possibility that the effect of one socially-constructed category depends upon the existence of one or more other categories. Understanding such intricacies of identity and experience can then positively influence assessment, diagnosis, and treatment towards effective and equitable client care. APA's *Multicultural Guidelines*, therefore, behoove psychologists and mental health practitioners to operate with a social justice and advocacy lens, following the same spirit that intersectionality discourse in the United States and elsewhere came into being.

Intersectionality's Relevance for Eating Disorder Treatment

Considering intersectionality in the field of eating disorders (EDs) is critical as, along with other mental health conditions, it has important. implications for risk, assessment, diagnosis, treatment, and outcomes (Burke et al., 2020). The categories suggested by Collins and Bilge (2020) in their definition of intersectionality (e.g., race, gender, age) are certainly relevant to EDs. However, others are likely as salient, including weight status, socioeconomic status, immigration status, and acculturative stress, among others (Burke et al., 2020). Such aspects of identity are also potential modifiers of health risk, treatment, and outcomes. However, in consideration of the APA *Multicultural Guidelines*, clinicians would be remiss if they did not consider the historical and cultural context of ED diagnostic criteria that spurred inequities in assessment and diagnosis from their foundation.

Culture, Eating Disorders, and the DSM

Culture is composed of the distinctive knowledge, customs, values, attitudes, norms, and beliefs of a society or community that are passed down over time and form the foundation of daily behaviors and practices including one's language and understanding of health and illness (American Psychiatric Association, 2022). Although culture is often treated as a static construct, like identity, culture is dynamic and changing over time. It informs daily life, the organization of family and community, and broader economic and political domains (American Psychiatric Association, 2022). The ED diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2022) were developed through a Western-focused lens, and primarily around White, relatively young, and economically advantaged women (Rodgers et al., 2018). Thus, individuals outside of these categories were at a disadvantage from all aspects of care—from screening and assessment to diagnosis and treatment—and these disparities continue (e.g., Coffino et al., 2019; Sonneville & Lipson, 2018). The most recent text revision of the DSM, the DSM-5-TR, acknowledges that current ED diagnostic profiles started as "cultural syndromes," but states such profiles have been adopted widely based on their clinical and research utility (American Psychiatric Association, 2022). Still, clinicians can enhance the cultural sensitivity and relevance of their care by understanding that no demographic, cultural group, or intersection of identities is immune to EDs, and EDs may present differently for individuals of various cultural and demographic groups.

Longstanding stereotypes regarding the demographics of those who do—and do not—have EDs is both a barrier to care and seeking treatment (Sonneville & Lipson, 2018). For example, historical stereotypes framed EDs as diseases of affluence (Gard & Freeman, 1996); however, EDs occur across the socioeconomic (SES) spectrum. It is posited that clinician bias based on these stereotypes contributes to disparities in ED diagnosis and care among those from economically disadvantaged backgrounds (Becker et al., 2003). The same stereotypes permeate society more broadly, and are likely why those from economically disadvantaged backgrounds are also less likely to perceive a need for treatment (Sonneville & Lipson, 2018). Studies indicate risk for EDs may actually be *higher* for those of lower SES (Burke et al., 2022). Conditions related to SES, such as food insecurity, are also predictive of binge eating over time (Hazzard et al., 2022). In 2021, 10.2% of U.S. households experienced food insecurity, which included nearly 13% of households that contained children (Coleman-Jensen et al., 2022). Notably, food insecurity disproportionately affects marginalized groups (e.g., Black and Hispanic individuals; Coleman-Jensen et al., 2022), placing these multiply marginalized youth and adults at greater risk for eating pathology. For example, data indicate Hispanic adolescents with food insecurity are more likely to engage in binge eating compared to non-Hispanic adolescents (Kim et al., 2021). Aspects of culture can influence how eating behaviors and food insecurity interact. For example, in times of food shortage, Bangladeshi girls are expected to restrict their food intake and sacrifice meals so that the boys of the family have enough to eat (Blum et al., 2019). In this case, cultural expectations by gender impact dietary restraint patterns influenced by food insecurity. Overall, data point to a strong link between binge-eating behaviors and other types of disordered eating behaviors in children and adolescents, highlighting the need to (a) not equate lack of food with lack of potential ED pathology, and (b) assess for ED pathology in youth with food insecurity (Bidopia et al., 2023). Mechanisms for understanding these connections are currently being investigated (e.g., Stadterman et al., 2022).

Other stereotypes have similarly persisted, which have dire implications for those not fitting the "skinny, White, affluent girl" (aka "SWAG," a term popularized by the media; Sonneville & Lipson, 2018) demographic. Indeed, for some African American adolescents, ED symptoms were totally ignored or dismissed by clinicians due to the erroneous belief that EDs were rare in African American populations (Becker et al., 2010). Epidemiological data dispute the erroneous belief that racial and ethnic minorities are not at risk for or experience EDs (Cheng et al., 2019). Racial and ethnic disparities in healthcare access are well known, and utilization of mental health services are lower among racial and ethnic minority groups due to systemic, social, and sometimes culturally specific barriers that remain unaddressed (Atdjian & Vega, 2005; Cook et al., 2017; Marrast et al., 2016; Planey et al., 2019; Udo & Grilo, 2018). As one example, South Asian women described judgement by members of their community, in the forms of general mental health stigma and social stigma, as significant barriers that maintain the taboo nature of speaking about and receiving treatment for EDs and mental health issues more broadly (Goel, Thomas, et al., 2022). Understanding the social barriers to care encountered by individuals with EDs is an essential step toward eliminating disparities in assessment, diagnosis, and treatment access. A study that hoped to understand the racial and ethnic disparities in treatment receipt among children and young adults found that Black and Hispanic youth receive outpatient mental health and substance use services at half the rate of non-Hispanic White youth, citing cultural values and a paucity of treatment providers as potential explanations (Marrast et al., 2016).

Other non-"SWAG" populations have also suffered from these disparities and oversight, including men and nonbinary individuals (Hartman-Munick et al., 2021; Strother et al., 2012), older adults (Mangweth-Matzek & Hoek, 2017), and those at the higher end of the weight spectrum (Kennedy et al., 2017). Though the DSM-5-TR includes significant revisions in the "Culture-Related Diagnostic Issues" sections for each ED, clinicians should be aware that the acknowledgement and understanding of such issues are still in the nascent stages and will inevitably evolve over time. Despite an increase in the recognition and exploration of culture in the context of EDs (Soh & Walter, 2013), our understanding of culture and EDs is still developing, which some believe prohibits our ability to provide culturally- sensitive treatment (Ramirez et al., 2018). As culturally adapted interventions produce greater reduction and remittance of symptoms across a range of psychological disturbances (Hall et al., 2016), continued work of this nature is critical for improving outcomes in underserved and underrecognized populations that may be overlooked by approaches that fail to account for the impact of marginalized and intersecting identities.

Extant Research on Eating Pathology and Intersectionality

Extant research supports the tenets of intersectionality theory as it relates to EDs. Specifically, research indicates ED prevalence among groups with multiple marginalized identities may be disproportionate to the prevalence noted with each individual identity in isolation (Burke et al., 2021; Rodgers et al., 2017). As one example, intersectional approaches have indicated that the intersection of gender and Latinx identities produces specific vulnerabilities; Latina adolescent girls' risk of purging behaviors is significantly greater than would be expected based on their ethnicity or gender alone, and significantly greater than their White female, White male, and Latino male peers (Beccia et al., 2019). Similarly, research examining the intersection of sexual orientation and race/ethnicity indicates a particularly high prevalence of EDs among Latinx and Black sexual minority individuals (Feldman & Meyer, 2007).

Which combinations of identities are held may differentially predict risk (e.g., multiracial individuals are not a monolith and experience differential risk depending on identity; Burke et al., 2021). As stated previously, the intersection of these socially-based identities within a given cultural context has implications for risk, assessment, and treatment (Burke et al., 2020). Those with multiply marginalized identities, secondary to historical, structural, and cultural influences, may be especially vulnerable (e.g., racial/ethnic, gender, and sexual minorities, those of lower socioeconomic status; Burke et al., 2022; Burke et al., 2020). Therefore, clinicians would be well advised to engage patients with an interview approach, such as the Cultural Formulation Interview, which provides an avenue for eliciting the clinically relevant features and experience of a patient's social identity (American Psychiatric Association, 2022). Such culturally appropriate evaluations consider both the sociocultural context and the individual living within that context (Kirmayer, 2016).

Risk/Prevalence

Eating Disorder Pathology

The importance of understanding the risk and prevalence of EDs in multiply marginalized individuals has been noted (Calzo et al., 2017; Smolak & Piran, 2012). Since EDs and subclinical disordered eating behaviors emerge most commonly during adolescence and persist into young adulthood (Neumark-Sztainer et al., 2011), a handful of studies have been conducted to understand how intersecting identities affect ED risk in young people. Early research in this area explored ED risk among young people by assessing whether risk associated with one identity was modified by a second identity. While some of this early literature did not find increased risk among multiply marginalized U.S. high school students using this approach (Austin et al., 2013), potentially due to using additive versus intersectional statistical models (Burke et al., 2020) or low sample size, there were increased ED behaviors in racial/ethnic and sexual minority groups independently (Austin et al., 2013). Contrastingly, recent work has indicated that ED prevalence may be higher among young people when accounting for their multiple identities than when accounting for each identity separately (e.g., Burke et al., 2021; Rodgers et al., 2017). As mentioned previously, Latina adolescent girls in the U.S. are at a higher risk of purging when considering the combined effects of their ethnic and gender identities (Beccia et al., 2019). Additionally, Asian adolescent boys in the U.S. of higher weight status are twice as likely to engage in dieting and overeating behaviors when considering their racial identity and weight status (Rodgers et al., 2017).

In a study of U.S. undergraduate and graduate students conducted by Burke and colleagues (2022), receiving a positive ED screen was significantly more likely among lower SES students than among higher SES students. The robustness of the relationship between screening positively for EDs by SES varied across social identities (gender, sexual orientation, race/ethnicity) and was especially notable among participants with intersecting marginalized identities. For example, ED prevalence was higher in lower SES Latinx sexual minority individuals and in Latinx sexual minority individuals, regardless of SES, when compared to Black and White sexual minority individuals (Burke et al., 2022).

In a study among South Korean male university students, sexual identity and university prestige (dichotomized into low- and high-prestige universities), were explored in relation to Korean men's cultural consonance to examine the risk of developing an ED (Monocello & Dressler, 2022). When cultural consonance, defined as the approximation of specific