EXAMINING THE LIVED EXPERIENCES OF COUNSELORS OF COLOR WORKING IN THE EATING DISORDER FIELD

by

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ABSTRACT

AMY LYNN BIANG. Examining The Lived Experiences Of Counselors Of Color Working In The Eating Disorder Field. (Under the direction of DR. CLARE MERLIN-KNOBLICH)

Though eating disorders (EDs) affect a diverse population of people, among professionals who treat EDs, Counselors of Color (COC) are under-represented (Jennings-Mathis et al., 2020). Because the ED field is predominately comprised of White professionals (AED, 2022; Jennings-Mathis et al., 2020), White invisibility may hinder counselors and researchers from recognizing oppression and injustices that occur in the ED field. The purpose of this Post-Intentional Phenomenological study was to bring awareness of the experiences of COC in the ED field and create a dialogue for systemic and social change related to their experiences. To do so, I interviewed 11 participants for the study, then analyzed interview material using a Post-Intentional Phenomenological design. Tentative manifestations, provocations, and productions emerged through a whole-part-whole analysis. The six tentative manifestations of *unprepared, isolating spaces, unspoken knowing, sense of duty, exhaustion,* and *microaggressions*; five provocations: *vulnerability, race as an asset, complexity, double bind,* and *credibility*; and two productions: *cultural inclusion* and *why we strive* offer valuable knowledge about the experiences of COCs in the eating disorder field. In light of this knowledge, I discuss implications for counselor education and the ED profession, along with limitations and future research considerations. Focusing attention on graduate school preparation, increasing racial diversity, and incorporating inclusive racial research, will strengthen the ED field and lead to more racially diverse, competent counselors who have culturally inclusive treatments to serve all clients with EDs.

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LIST OF ABBREVIATIONS

COC	Counselor of Color
ED	Eating Disorder
CIT	Counselor in Training
PIP	Post-Intentional Phenomenology
HLOC	Higher Level of Care
CACREP	Council for Accreditation of Counseling and Related Educational Programs
POC	People of Color
AED	Academy of Eating Disorders
STF	Systems Theory Framework
CRT	Critical Race Theory
EBT	Evidenced Based Treatment
CEDS	Certified Eating Disorder Specialist
SES	Socioeconomic Status
CESNET	Counselor Education and Supervision Network
BED	Binge Eating Disorder
AN	Anorexia Nervosa
BN	Bulimia Nervosa
IAEDP	International Association of Eating Disorder Professionals
LIS	Library Information Systems

Chapter 1: Introduction

"In order to carry a positive action, we must develop here a positive vision."

-Dalai Lama

In the United States, eating disorders are prevalent among people of all races and ethnicities (Palmer, 2008). What was once considered an illness only affecting skinny, White, affluent girls (Sonneville & Lipson, 2018) has become entrenched among people of all sizes, races, socioeconomic classes, and genders (Qian et al., 2022). With the ubiquity of diet culture and the increased relevance of social media in society today, it is not surprising that disordered eating and eating disorders are increasingly prevalent in the U. S. (Hummel & Smith, 2015; Opara & Santos, 2019). When a person is diagnosed with an eating disorder (ED), their most effective treatment is an immediate referral to an ED professional (Johns et al., 2019). Such professionals include psychologists, social workers, and clinical mental health counselors. Though EDs affect a diverse population, among professionals who treat EDs, Counselors of Color (COC) are under-represented (Jennings-Mathis et al., 2020).

Historically, racial and ethnic diversity in U.S. professional occupations lags compared to the national profiles of racial groups (Jennings-Mathis et al., 2020). This pattern also appears to be the case in the ED field (Lundgren, 2022; Jennings-Mathis et al., 2020). Multicultural research around EDs has slowly increased over the last decade (Halbeisen et al., 2022); however, only one study considered the profession's racial/ethnic makeup (Jennings-Mathis et al., 2020). In that study, the authors attributed the lower numbers of COCs to systemic and social barriers, such as the ED pipeline, homogeneity of the profession, and myths or stereotypes about EDs (Jennings-Mathis et al., 2020).

Cultural awareness and sensitivity are aspirational ideals of the counseling profession and embody inclusion, diversity, and social justice (American Counseling Association, 2014). To

that end, the standards set forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) require implementing culturally relevant strategies for the admission, recruitment, and retention of masters and doctoral students (Thacker & Minton, 2021). These goals have recently increased the number of racially diverse students entering graduate counseling programs (CACREP, 2016a). However, racial and ethnic minorities continue to face numerous adverse professional experiences related to their racial identities (Thacker & Minton, 2021), which may also indicate why COC are underrepresented in the ED field.

Further evidence of the counseling profession's commitment to inclusion, diversity, and social justice is the Multicultural and Social Justice Counseling Competencies established by Ratts et al. in 2016 based on the work of Sue, Arredondo, and McDavis (1992). The values inscribed in the competencies set aspirational ethical behaviors for counselors, including understanding how privilege and oppression influence their experiences and how to create culturally affirming counseling relationships for all clients. Though these values help build culturally competent counselors, racism, White supremacy, and oppression continue to be pervasive in the professional environment (Thacker & Minton, 2021).

Because the ED field is predominately comprised of White professionals (AED, 2022; Jennings-Mathis et al., 2020), a danger exists that White invisibility hinders counselors and researchers from recognizing oppression and injustices that occur in the ED field. Whiteness remains invisible because it is not generally named (Schlesselman-Tarango, 2016). ED researchers know that diverse clients need culturally responsive treatment, and research shows progress in becoming inclusive in ED counseling (Cheng & Merrick, 2017; Soto et al., 2019). However, the lack of research on COC in EDs reiterates a disconnect between the value of racial

diversity in counseling and the lack of increased racial/ethnic diversity among COC. This research study is a beginning step in discovering the experiences of COC in the ED field that can lead to actionable improvements in the counseling profession.

Concepts of Interests

Multiple concepts need addressing to understand the dynamics of working in the ED field and the need for this study. The following section begins with a justification for the language used in the study, then the primary concepts of interest in this study. They are professional demographics, ED statistics, working with clients, racial/ethnic matching, specialization and training, and influencing factors.

Nomenclature

Clarifying terminology is imperative to informing research, identifying interchangeable terms, and reducing racism in language (Haeny et al., 2021). In this study, the term, *people of color* (POC), refers to racial or ethnic groups in the United States (U.S.) that are underrepresented or oppressed by the White majority. This term may include but is not limited to, Black or African Americans, Native or Indigenous people, Hispanic or Latine, Asian Americans, Caribbean Blacks, Africans, and Pacific Islanders. *People of color* is considered less pejorative than *minority* (American Psychological Association, 2020).

Black and African American are used interchangeably in academic writing. However, Hall et al. (2015) studied participants' (N = 172) negative stereotypes associated with both terms and found that the negative stereotype content for Black was significantly more negative than for African Americans (p = .04, d = .49). They also found that the negative stereotype for African Americans was not significantly different from the perceived negative stereotypes of Whites (p = .62). Due to these findings, I will use the term, African American, in this study. Similarly, the

preferred term Latinx is most often found in academic settings. However, a recent study of students revealed a common belief that the term was a privilege for academics and social justice advocates. When these Latin American students are in their communities in the U.S. and abroad, they do not use the term (Salinas, 2020). Recently, advocates in South American countries have put forth the term Latine to be gender inclusive and to reject the x that represents colonialism (Collins & Santiago, 2022). For this study, I will use Latine for the inclusivity of all people of Latin descent.

I have chosen to use Counselor of Color (COC) instead of the term *racially diverse counselor*. Racial diversity must include White people; otherwise, it continues to signify the White race as the norm. Another term to consider is race/ethnicity. Since research language often interchanges the terms ethnic and racial, despite having different definitions, this study follows Cabral and Smith (2011) and combines the term into racial/ethnic or race/ethnicity.

Lastly, the designations of racial groups are all capitalized in this proposal (e.g., African American, White, Hispanic, Asian American). In the past, disputes among anti-racism activists expressed concern that the term *White* and *Whiteness* were the standards by which to measure all other races. Moreover, capitalizing *White* legitimized the norm structure of Whiteness (Foster, 2003). However, failing to capitalize *White* when capitalizing other racial terms maintains Whiteness as the standard, but keeping it lowercase ignores Whiteness as a race, perpetuating White invisibility (Mack & Palfrey, 2020). Thus, I have chosen to capitalize all racial group designations in this proposal.

ED Professionals' Demographics

One primary concept necessary to review is the demographics of current ED professionals. In a recent Academy of Eating Disorders survey of ED counselors worldwide,

researchers found that 86% did not identify as part of an ethnic or racial minority in their home country (AED, 2022). Though this study incorporated multiple countries, counselors across all specializations in the U.S. are also predominantly White at 64% (Material USA, 2019). A 2021 report on counseling students enrolled in CACREP programs confirmed this trend. See Table 1.

Table 1
Students Enrolled in CACREP Counseling Programs

Race/Ethnicity	Total %	US Population Average
American Indian	0.56%	1.30%
Asian	2.66%	6.1%
Black	16.71%	13.60%
Hispanic	9.96%	18.90%
Multiracial	3.17%	2.90%
White	55.11%	59.3%

Note: Data retrieved from US Census 2020 and CACREP Vital

African American counselors are well represented with respect to the population average (18% compared to 14%), but the need for African American counselors is unmet. Given persistent racism and oppression in the U.S., African Americans may need more mental health services, resulting in fewer African American counselors to meet their needs if racial matching is preferred (Meyer & Zane, 2013). There are disproportionately fewer counselors for Hispanic and Latine clients compared to the population averages of 10% compared to 19% (Bureau, 2021). This disproportionality results in limited access for clients desiring a racial match if that is their preference. Similarly, Asian Americans are one of the fastest-growing ethnic groups in the U.S., making up only 2.6% of counseling students but 6% of the population average (Bureau, 2021). Currently, there are no detailed statistics on the racial make-up of counselors working in the ED

field. However, knowing that 86% of the AED study participants are from the majority groups in their countries suggests limited racial/ethnic diversity in the ED field (AED, 2022).

Along with the homogeneity of the ED counseling field, misperceptions about EDs can be a barrier for counselors to recognize the need to train in EDs. United States culture may have skewed the reality of the need for COCs. Persistent Western stereotypes of affluent, White women as the face of EDs have limited most people's understanding of how EDs present in various races and ethnicities, impacting treatment approaches and those who might seek treatment (Acle et al., 2021, Jennings-Mathis et al., 2020). Myths about POC being protected from EDs, as they do not prescribe the dominant American beauty standards, perpetuate the fallacy that EDs only encompass anorexia and thinness (Palmer, 2008).

Eating Disorder Statistics

EDs are dangerous and can have severe mental and physical health consequences. They arise as complex, maladaptive coping mechanisms related to a vast array of stressors (Franklin, 2020). The ED population presents a high risk for psychiatric and medical issues, requiring multiple levels of care, including in-patient, residential, partial hospitalization, day treatment, and outpatient treatment. The current incidence rates of EDs in the United States are Bulimia at 4.6%, Anorexia at 2%, and Binge Eating Disorder at 3.5% (National Eating Disorders Association, 2022). Along with the mental anguish these disorders impart, the healthcare impact is high, meriting more treatment and training efforts than other mental health disorders (Lazare et al., 2021). Additionally, EDs have the second-highest death rate among all mental health disorders, killing one person every 52 minutes, equating to more than 10,000 people annually. According to National Eating Disorder Coalition (2018), approximately 29 million people in the United States will have an ED in their lifetime (NEDC, 2018).

Working with ED Clients

Researchers have found that EDs can be challenging to treat. Counselors facing high client relapse rates of 9%-52% (Khalsa et al., 2017), emotional exhaustion due to treatment resistance, and extra hours working (Warren et al., 2013) may struggle to remain working with this population. Furthermore, a recent study on the lived experiences of ED professionals characterized working with ED clients as draining, demoralizing, and frequently feeling on edge (Graham et al., 2020). These experiences may lead to losing counselors and creating long waiting lists for clients needing treatment. ED professionals are also often under-resourced, have large caseloads, and are unable to accept high numbers of referrals (Johns et al., 2019). Having inadequate numbers of ED professionals results in clients facing long waitlists, seeking less suitable treatment, and delaying their treatment, which can prolong the illness and result in a poor prognosis (Herpertz-Dahlmann et al., 2001).

Notably, however, most research on the challenging nature of treating EDs has been conducted with White participants (Halbeisen et al., 2022). Research from the voices of COCs is lacking. Working in White spaces, COCs may experience the same challenges as other counselors working with ED clients. However, they also may endure bias, racism, and microaggressions prevalent in the workforce (Wong et al., 2014). As younger generations move into the workforce, many consider diversity and inclusion essential for entering a specific career (Kochhar, 2016). Exploring the experiences of COCs in the ED may identify needed systemic changes and entice more COCs into the ED field.

Racial/Ethnic Matching

When studying COCs, it is valuable to understand the concept of racial/ethnic matching. As clients seek counseling, some want to match with a counselor who speaks their native

language (Cheng & Merrick, 2017) or is racially matched (Meyer & Zane, 2013). COCs offer clients of color access to treatment with a similar counselor regarding attributes such as gender, race, or cultural beliefs (Meyer & Zane, 2013; Steinfeldt et al., 2020). This preference for similar shared traits makes up the concept of racial matching. Racial matching is pairing two people together based on their racial makeup, not necessarily their racial identity (Ladany et al.,1997).

Racial matching describes culturally responsive care and is a way to potentially reduce mental health disparities for ethnic minorities by having access to helping professionals from the same racial/ethnic group (Meyer & Zane, 2013). Researchers have found favorable outcomes with racial matching for African American, Asian American (Meyer & Zane, 2013; Steinfeldt et al., 2020), and Latine clients in counseling (Reyes-Rodriguez et al., 2014). These outcomes include positive treatment engagement, retention (Meyer & Zane, 2013), number of sessions attended, and improved Global Assessment of Functioning (GAF) scores (Kim & Kang, 2018).

Overall, treatment-seeking among people with EDs is low, with 43% seeking treatment at some point in their lives and just 28% of all people with EDs receiving treatment (National Eating Disorders Association, 2022). These rates are especially low compared to 71% of people with depression receiving treatment (NIMH, 2022). Such a low treatment rate can be detrimental, as ED recovery is less likely when left untreated, and recovery prognosis is lower with more prolonged untreated symptoms (Hamilton et al., 2022). POC are less than half as likely to be diagnosed or receive treatment as White people (Sonneville & Lipson, 2018). Moreover, treatment-seeking for POC with EDs has historically been lower than for White people (Sinha & Warfa, 2013). A lack of racial/ethnic diversity in counselors specializing in EDs may be one reason for lower treatment-seeking rates in POC.

Specialization and Training

CACREP established the standards for many graduate programs in counseling (CACREP, 2016a). These standards include designated program area standards in Clinical Mental Health Counseling; School Counseling; Rehabilitation Counseling; Marriage, Couple and Family Counseling; Career Counseling; Addiction Counseling, and Student Affairs in College Counseling (Bobby, 2013; CACREP, 2016a). Counselors in training (CITs) in clinical mental health counseling programs graduate with an overall ability to counsel and diagnose clients in various settings (Henriksen et al., 2010). ED specialization is one of those settings, and within the clinical mental health counseling program area, specific opportunities and experiences can lead a CIT to desire further specialization in specific disorders, such as EDs.

Eating disorders are complex, and treatment is multifaceted. Specialized training is required for counselors to be competent in working with this population. Moreover, counselors must follow the American Counseling Association (ACA) ethical standards, which require competence in the specialty of their engaging practice. Competence is based on appropriate education, specified training, and supervision. (C.2.a, C.2.b). These ethical codes require training beyond introductory graduate counseling courses (Williams & Haverkamp, 2010). For example, when Von Ranson and Robinson (2006) surveyed 52 counselors about their training for treating EDs, they found that participants received ED training through a combination of attending workshops and seminars (71.2%), self-education/reading (53.8%), informal supervision from a trained colleague (57.7%), clinical graduate training (42.3%), and formal supervision (32.7%). As reflected in most of these training outlets, ED training after graduate school often requires extra time, money, and effort. Such barriers may impact counselors' decisions to embark on this field.

Influencing Factors

Although no found research to date includes an overview of why counselors do or do not specialize in EDs, researchers have examined why people specialize in other health care specialties. Barnes et al. (2012) found individual-level factors such as gender, previous work experience, and knowledge of the specialty as influences on specialization. Program-level factors, such as role models in the program, relationships with professors, student associations, professional development opportunities, and class assignments, were also found as important factors.

Other researchers found additional factors, such as personal experiences (Graves & Wright, 2007), potential enjoyment of the profession, service to others, family and friends (Tamayose et al., 2004), interest in the specialization, willingness to seek training, and feeling prepared to specialize (Foster et al., 2009) as influential in choosing specialties. These studies show what factors may predict the choice of specialization within the counseling field. Notably, however, none of these studies was specific to EDs or COCs, and researchers have conducted no found research on this topic, which leaves a gap in the literature.

If counseling leaders and counselor educators can understand why a counselor does or does not specialize in a counseling specialty like EDs, they might be able to increase the number of counselors in that specialty more effectively. Additionally, learning about the experiences of COCs working in the ED field can offer insight that may help support their efforts in the field. Thus, in this study, I sought to fill a gap in the literature by exploring the lived experiences of COC in the ED profession that led them to choose this specialization and remain working with EDs.

Study Purpose and Research Question

The purpose of this Post-Intentional Phenomenological study was to bring awareness of the experiences of COCs in the ED field and create a dialogue for systemic and social change related to their experiences. The research question guiding the study was, "What are the lived experiences of COCs choosing and working in the ED field?".

Significance of the Study

Multicultural competency and social justice are core concepts that guide the counseling profession (Ratts et al., 2016). However, the profession's focus on creating culturally competent counselors may sometimes overshadow the need to discuss continued systemic barriers and White invisibility. Engagement in racial justice and equity cannot occur through lip service instead of confronting White supremacy (Brown et al., 2018). Research should incorporate the voices of underrepresented people to make fundamental changes in the counseling field (Halbeisen et al., 2022). In this study, I explored the experiences of COCs, giving voice to the phenomenon of working in the predominantly White profession of EDs.

To date, only one found study examined why counselors chose or did not choose to specialize in clinical counseling (Wessell, 1974). Although the results of this study broadly clarify counselors' professional choices, the researcher did not examine race among participants. As society recognizes the need for a more diverse workforce, identifying systemic influences and barriers is critical to increasing the workforce (Phillips & Malone, 2014). The specialty of ED counseling is among the fields that would benefit from an overall increase in counselors and an influx of COCs to meet clients' needs best. By increasing racial/ethnic diversity among counseling professionals, POC may encounter fewer health disparities and less treatment avoidance (Jennings-Mathis et al., 2020).

This study filled a gap in the research. It informed counselor educators and counseling leaders about the experiences that COCs identified as necessary to lead them to work in the ED field and how their experiences within the ED field impacted them. After acquiring this knowledge, counselor educators and ED professionals may recognize the changes needed to create a more inclusive work environment for COCs.

Assumptions

I held the following assumptions for this study:

(1) Participants could access video conference computer technology for the qualitative interview used in the material collection.

(2) Participants participated honestly in the interview used in the material collection.

(3) Participants had additional training in EDs (e.g., workshops, CEUs, certifications)

Delimitations

I consciously set delimitation boundaries for the study to achieve the aims and objectives (Theofanidis & Fountouki, 2018). Delimitations associated with this study are:

(1) The sampling for this study was purposive.

(2) Study findings were obtained through interviews with the researcher.

(3) Study participants were counselors and social workers with a minimum provisional license in their respective fields.

(4) Study participants treated clients with EDs in the past or were currently training to work in the field of EDs.

(5) Participants identified as COCs.

Limitations

Limitations are potential study weaknesses outside the researcher's control (Theofanidis & Fountouki, 2018). The limitations associated with this study were:

(1) Participants may work in various settings that offer extensively different experiences (e.g., hospital, recovery center, or private practice).

(2) No standard exists regarding what constitutes specialization in EDs. This lack of clarity in the helping professions may have hindered some participants from believing they meet the study requirements.

(3) Participants may have been less open about their experiences with a White interviewer. This reticence may have led to a less comprehensive and accurate study.

Definitions

For this study, the following definitions enhance understanding of concepts and terminology.

- *Counselors* are individuals who self-report that they have received a master's degree in counseling, social work, or psychology and are licensed to practice within their state or country.
- *Race/Ethnicity* is defined as an individual's self-identified racial or ethnic identity.
- *Racial Matching* refers to a counselor and client of the same race working together.
- *Racial Microaggressions* are “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or harmful racial slights and insults to the target person or group” (Sue et al., 2007, p. 273)
- *ED Specialization* refers to counselors who self-report having received additional certifications (e.g., Certified Eating Disorder Specialist), attended ED workshops/conferences, completed the

online training, attended ED certification programs at graduate schools, or received direct supervision and training from a clinical supervisor who has specialized in EDs.

- *White Privilege* is defined as the social and economic advantages that White people have by their race in a culture characterized by racial inequality (Merriam-Webster, n.d.)

Chapter Summary

In this chapter, I provided a brief overview of the need for racial awareness and ethnic matching, along with demographics of ED professionals, ED statistics, the need for training, and influences for specializing in EDs. In the significance of the study, I reiterated the need for understanding the lived experiences of COCs working in a predominantly White profession. This knowledge may inform counseling programs and professional associations about needed changes for equity and inclusion in the ED field.

Organization of the Study

Comprised of five chapters, this dissertation is written as follows: Chapter One included background information on the problem, concepts of interest, and the need for the study. I also introduced the phenomenon I intend to study and identified the research question. In Chapter Two, I examine relevant literature on ED counselors, other professional POCs lived experiences, racial/ethnic matching, and the ED pipeline. Chapter Two concludes with a review of Critical Race Theory and Systems Theory Framework as contextual theories. Chapter Three covers Post-Intentional Phenomenology and methods associated with this design, including research design, participants, sampling, material collection, and analysis. Chapter Four presents the findings from the material analysis, and Chapter Five concludes with a discussion of the findings, limitations of the study, and future considerations.

Chapter 2: Review of the Literature

"Diversity is a fact. Equity is a choice. Inclusion is an action. Belonging is an outcome."

-Arthur Chan

The purpose of this study was to bring awareness of the experiences of counselors of color (COCs) in the eating disorder (ED) field and create a dialogue for systemic and social change related to their experiences. In this chapter, I present the relevant research literature and context related to COCs specializing in ED. This literature includes demographics of ED counselors, the ED pipeline, influences for specialization and training, the concept of racial/ethnic matching, and other lived experiences of professional POC. I also present an overview of Critical Race Theory and Systems Theory Framework as contextual theories for analyzing collected material. In the final section, I summarize the literature and its relevance to this phenomenological study.

In this study, I used a post-intentional phenomenological framework. From the post-intentional phenomenological perspective, the literature review should not be extensive. The primary goal of this review was to capture possible influences and experiences related to the phenomenon but avoid trying to predict or direct what might be discovered (Vagle, 2018). Though research builds upon established findings, phenomenological research is about the researcher's openness to the phenomenon and not compromising the experience by looking for material that fits a preconceived agenda based on previous research (Vagle, 2018). In the following review, I attempted to balance the established expectations for literature reviews and limit the chance of setting an a priori explanation of what will be found. The literature reviewed established the purpose of the study and oriented me to possible aspects of the phenomenon.

Eating Disorder Therapists

Understanding the demographic makeup of any profession allows for awareness of inequity or exclusion for all people. There is limited demographic information about those who work in EDs. However, in a recent study by the Academy of Eating Disorder (AED), researchers elicited this information to understand better the need to increase diversity, equity, and inclusion (Lundgren, 2022). Knowing the demographics of professionals working in EDs established this study's need and value.

Demographics

The AED globally surveyed their members (N = 237, 12% response rate) and reported their membership as predominately women (86%) in a majority racial or ethnic group (86%), who are heterosexual (82%), and of the country's majority religion (93%). Most members reported that they do not have a disability (86%) and do not live in a physically larger body (87%). Sixty percent of respondents reported their professional role as clinicians and 43% as researchers (Lundgren, 2022). These demographics are limited to counselors who belong to AED and may not indicate counselors who work with EDs but are not associated with AED; however, this information informs the field that there is a possible overall lack of diversity for ED professionals.

In addition to the AED, Jennings-Mathis et al. (2020) also studied the ED workforce. They conducted a global demographic analysis of ED counselors across 26 countries, including the U.S. They found participants (N = 512) to be 89% female, 84% heterosexual, 65% healthy weight, 73% White, and 22% with a lifetime diagnosis of an ED. They found that 80% had a master's degree or higher, and 63% reported EDs as their primary area of expertise.

Demographic material is not systematically collected from all members of ED professional associations (AED, personal communication, Jan 2022), which limits the ability to present fully comprehensive statistics of those who work in this field. However, Lundgren's (2022) and Jennings-Mathis and colleagues' (2020) studies demonstrate the underrepresentation of COCs in the ED field. Their research also highlights that COCs specialize in ED work alongside predominantly White professionals. This experience is the phenomenon I explored in this study: COCs' experiences choosing and working in the ED field.

Personal Experience with Eating Disorders

Personal experiences of EDs are prevalent among counselors working in the ED field. Multiple studies have shown rates of EDs ranging between 24% and 47.5% for ED counselors (Bachner-Melman et al., 2021; Barbarich, 2002; Costin, 2002; De Vos et al., 2016; Warren et al., 2013), with only 64.2% of those counselors receiving treatment (Barbarich, 2002). These prevalence rates are especially striking when compared to the general population, as ED counselors have a significantly higher prevalence rate of 12.8% anorexia nervosa (AN) and 13.5% bulimia nervosa (BN), compared to 2% for AN and 4% BN, respectively (Barbarich, 2002). Such statistics indicate that counselors with histories of EDs often seek employment in settings specialized for this population (Bachner-Melman et al., 2021; Costin, 2002) and may highlight an influential factor in the decision to specialize in this field. Notably, however, as there is a deficit of samples of POC in all forms of ED research (Palmer, 2008), there is no delineating research rates of EDs for COCs.

If counselors have recovered from an ED or have significant others who have struggled with EDs, they may be able to make meaning of clients' struggles effectively and use their experiences to guide their career choices. Researchers acknowledge the potential advantages an

ED counselor may possess when having experienced an ED firsthand. These benefits may include more insight, increased understanding, decreased client shame, stronger therapeutic alliance, and greater awareness of subtle behaviors associated with the disorder when compared to counselors without personal ED experience (Bachner-Melman et al., 2021; De Vos et al., 2016; Warren et al., 2013). In Warren and colleagues' (2013) study, 89% of participants believed their ED history had only positive effects on the treatment of their clients. Participants described these advantages as having (1) a unique personal understanding of the disorder and its treatment and (2) increased perspective and nuanced knowledge.

Despite these benefits, researchers have also noted some disadvantages to ED counselors with EDs. Findings, such as over-identification and enmeshment with clients and using treatment to heal themselves (Conchar & Repper, 2014; De Vos et al., 2016), indicate concerning interactions that would require supervision. Regardless of the advantages and disadvantages of previously having an ED, personal experience and the possible self-efficacy from recovery may influence the decision to work in this field and impact the counselor's perception of helpfulness.

Eating Disorder Pipeline

EDs are complex and encompass more than a relationship with food, eating behaviors, and body image. EDs require an integrative treatment approach encompassing mental, medical, and nutritional needs. Clients with EDs need high-quality, trained counselors that recognize, diagnose, manage, and utilize research-based treatment (Franklin, 2020). Before exploring how one becomes a counselor, understanding the influences that begin the journey is helpful.

Career Influences

When pursuing a career in counseling, having a personal experience with mental health counseling or being a *wounded healer* (Conchar & Repper, 2014) are two common influences.

POC are less likely to seek mental health treatment (Regan et al., 2017), which may limit the influence personal experience with a mental illness or seeing a counselor has on the decision to pursue a counseling career. As for the second common influence, the term, wounded healer, describes the experience of being wounded and devoting one's life to healing others. As wounds from oppression and experiences with racism are prevalent, the wounded healer may influence COCs (Conchar & Repper, 2014).

Once people have chosen to pursue counseling careers, deciding to specialize in EDs is an additional choice that may begin before, during, or after graduate school. In the only found study on counselors' career specializations (N = 38), Wessell (1974) found that career specialization occurred for half of their counselor-in-training (CIT) participants when their initial interest in counseling occurred. The other half chose their specializations during and due to experiences in graduate training. Additionally, counselors choose specialties due to their desire to help others, learn about themselves, gain interpersonal skills related to the specialty, and work with the population within the specialty (Wessell, 1974).

Graduate School

Training to increase skills and knowledge while attaining ethical competence begins in graduate counseling programs and continues once a counselor enters the workforce (Henriksen et al., 2010). To become a licensed counselor, one must obtain a master's degree from a graduate counseling program. This first step in the journey can mark a barrier for POC due to a program's inability to recruit and retain POC related to the invisibility of Whiteness (Brown et al., 2018). In our society, Whiteness is a default standard from which racial/ ethnic minorities are evaluated (Sue, 2006). Using this metric for admission to graduate school limits the acceptance of POC

who do not fit White Eurocentric standards. This Whiteness comparison can be a barrier to a career in counseling.

Though research on ED training in graduate school is sparse, two studies offer some insight into the perception of ED instruction at the graduate level. Levitt (2006) surveyed 59 program directors from CACREP counseling programs across the United States. They inquired about the school's programs for preparing counselors to work with EDs and body image concerns. Eighty-nine percent (N = 50) believed their program currently or potentially would integrate ED information into the curriculum. They believed most students obtained ED knowledge through course instruction, class assignments, and specialty courses (Levitt, 2006). When asked which courses infused ED information into the curriculum, 35 respondents (62.5%) indicated the training was directly covered in specialty courses and infused within psychopathology, diagnosis and assessment, life span development, and adolescent counseling courses (Levitt, 2006). Though the findings from this study suggest infused ED training throughout courses in counseling programs, the study sample was small, and the respondents were program directors and not counseling students.

Conducted almost twenty years after Levitt's (2006) study, research findings from Labarta et al. (2023) point to a different reality for counseling students. Labarta et al. (2023) conducted a mix-methods study exploring the challenges clinicians face with ED treatment. Participants (N = 109) were helping professionals (e.g., counselors, social workers, psychiatrists) who treated clients with EDs. When asked about graduate school coursework, 73.4% of the participants indicated that none of their graduate coursework focused on EDs. Going further, when asked about the total number of hours of instruction on EDs within their counseling program, 41% of participants indicated a total of instructional time between 1-5 hours, while

26.6% reported having none (Labarta et al., 2023). When asked to indicate the significant challenges to ED treatment, the most common response was the lack of graduate-level and specialized training (59.6%), with insurance issues second (51%). In the write-in portion, the need for more culturally responsive care was an emergent theme (Labarta et al., 2023). These findings may infer that limited training during counseling programs becomes one of the significant challenges when treating clients with EDs, and there is a call for culturally responsive care.

In addition to course work, a potential pipeline to ED specialization begins with counseling students' placements in practicum and internship sites during graduate school. These learning experiences develop areas of potential expertise for students based on the site, the client population, and the expertise of supervisors (Henriksen et al., 2010). Access to ED placements is limited and tends to "attract a specific sort of person" (Jennings-Mathis et al., 2020, p.1073), characterized as White, thin females (Lundgren, 2022; Jennings-Mathis et al., 2020). Unfortunately, some counseling programs reinforce the myth that EDs are a White woman's illness, dissuading POC CITs from seeking ED placement sites (Jennings-Mathis et al., 2020). Combating this myth with culturally sensitive professors, mentors, and peers can encourage POC CITs to explore ED placement sites and refine interests leading to an area of specialty.

Beyond practicum and internship placements, three other experiences can be influential in specializing. First, Wessell (1974) found that counselors and teachers encouraging students to follow their passions led to specializing. The second is working in an agency before entering the counseling program so future counselors can work with their desired population (Graves & Wright, 2007), including clients with EDs. Last, exposure to special programs, such as

conferences or workshops, offers more awareness of specialties within the counseling field (Graves & Wright, 2007).

Post Graduate Training

The American Counseling Association (ACA) recognizes the master's degree as the entry-level degree for professional counselors and considers this level of counselors as generalists (n.d.). After earning a master’s degree and professional licensure, counselors are responsible for continued education to maintain their licensure. Continuing education requirements allow counselors to increase their knowledge in ten training areas distinguished by National Board for Certified Counselors (2015): Counseling Theory/Practices and the Counselor Relationship, Human Growth and Development, Social and Cultural Foundations, Group Dynamics, Career Development, Assessment, Research, and Program Evaluation, Professional Identity and Practice Issues, and Wellness and Prevention. Trainings are offered in many formats, such as webinars, conferences, workshops, formal certification programs, and college courses. Counselors may start increasing their skills in a specific disorder, such as EDs, from these trainings.

After completing various trainings, a counselor may specialize in a narrowly focused area, requiring advanced knowledge beyond basic skills. As the ACA code of ethics prohibits working with clients on issues clearly outside the counselor's expertise (ACA, 2014), it behooves a counselor to access specialty training designed for the specific practice of working with EDs. In addition to continued education, specialty training is often obtained in work settings with appropriate supervision (Henriksen et al., 2010). This training does not define the counselor but offers insight and techniques specifically for the client's issues and allows them to feel confident that their counselor has specialized training (Henriksen et al., 2010).

As counselors enter the field, they may feel unprepared to work with EDs without additional supervision and training. For example, Reid and colleagues (2010) studied a group of ED professionals (N = 18) who received training through attending conferences and short training courses about ED counseling. They found that participants reported that their training focused on EDs but did not feel they had the specialist knowledge to effectively counsel the ED population. They also reported that their training was inadequate and did not have the support to further their knowledge (Reid et al., 2010). Many counselors may feel the same way as these study participants as they begin to work with clients with EDs and realize the depth and breadth of knowledge required to offer effective treatment. Hearing the lived experiences of COC in the ED field that pertain to their acquired training offers a pathway for others to follow.

Racial/ Ethnic Matching

As society maintains its White-centric belief system that continues to oppress POC, it is understandable for POC to prefer seeing a counselor of the same race. People choose to associate with those perceived as similar to them, have similar worldviews, and have similar physical attributes (Byrne, 1971, as cited by Montoya & Horton, 2013). Racial/ethnic matching follows the same premise as similarity-attraction. When a client requests a counselor of the same race/ethnicity, there is a presumption of shared cultural experiences that establishes trust, which may not occur with a counselor from another race (Cabral & Smith, 2011). In a recent qualitative study (N=16), Cofield (2022) found that cultural comfort and connection as themes for African American men when seeking a counselor. Participants shared sentiments such as feeling a White counselor would not be equipped to help an African American man and have no desire to explain what it is to be an African American man. Additionally, they noted that White counselors would

not understand stereotypes or how to connect through shared experiences. These powerful beliefs support the necessity for access to COC (Cofield, 2022).

Racial/ethnic matching may improve client outcomes in counseling by enhancing the therapeutic alliance and reducing mistreatment concerns (Cabral & Smith, 2011). For example, Smith and Trimble (2016) conducted a meta-analysis (*N*= 52) on racial matching research. They found that Asian American clients benefited substantially when paired with a therapist of their race and ethnicity (*d* = .46) compared to African American and White clients. Additionally, in the study by Meyer & Zane (2013) (*N*=102), clients strongly preferred to be matched with a counselor similar to their race in the African American community, as there is consistent evidence of mistrust of White counselors. Kim and Kang (2018) (*N*=644) found that when racially matched with their counselors, African American clients increased the number of sessions attended, and their global functioning scores increased (GAF). Perhaps racial matching initially establishes a more potent therapeutic alliance, leading to more attended sessions and better overall functioning. In addition to Asian American and African American clients, researchers have found that Latine clients preferred a counselor from the same ethnic background; however, they did not evaluate other counselors more negatively due to race/ethnicity (Cabral & Smith, 2011; Meyer & Zane, 2013).

Racial Identity

Though racial/ethnic matching is an essential concept in understanding the needs of the client, racial similarity is not equivalent to racial identity. Multicultural competency is not guaranteed based on similar race/ethnicity, partly because not all racial or ethnic group members have the same level of racial identity (Ladany et al. 1997). The racial identity model, created by Helms (1990), posits several stages or ego statuses that reflect beliefs and feelings about race and

other races. However, a racial category does not imply a belief or feeling about race (Ladany et al., 1997). People within the same race/ethnicity can be at various stages of ego statuses. Similarities between people of different races in the same racial identity stage have more substantial predictor outcomes for a working alliance than people of the same race at different identity stages (Ladany et al. 1997). Though some clients prefer racial matching, the presumption of similarity based solely on race may lead to disappointment and feelings of disillusion (Cabral & Smith, 2011). Although racial/ethnic matching is not the ultimate solution to the barriers to mental health for POC, it still presents a beneficial option to consider in supporting the needs of ED clients. As no found literature exists on the perspectives of COC working in the ED field, this study filled a gap between understanding the lived experiences of counselors of color and their experiences with racial matching.

Barriers for COC

In their multi-methods study of clinicians and researchers in the ED specialty (N=512), Jennings-Mathis et al. (2020) found three main themes and six sub-themes for why racial/ethnic diversity is lacking among counselors in the ED field. The first theme was the homogeneity of the existing field of ED counselors. Contributors to this homogeneity are issues with mentorship, selection bias, and lack of diverse leadership. Participants expressed the need for courage when counselors do not fit the perception of an ED counselor. They also noted the elitism of academics and clinical psychologists who are less than welcoming of underrepresented groups. Additional concerns of unrecognized bias by gatekeepers, White privilege, and educational elitism hinder diverse COC from entering the ED field (Jennings-Mathis et al., 2020).

Next, Jennings-Mathis and colleagues (2020) identified issues with the ED pipeline. These barriers in the pipeline include the three sub-themes of access to higher education and the

financial burden with additional training, access to clinical experiences, and research priorities that do not include COC. The last theme by Jennings-Mathis and colleagues (2020) was stigma, bias, stereotypes, and myths. Respondents felt that stigma and bias were directed toward COCs by other counselors and clients. They shared that having body sizes that do not fall within the normal weight range created distrust among professionals and clients. These stereotypes perpetuate the idea that EDs present in a certain way. Some final themes that play a role in the barrier to increasing diversity in EDs are high educational costs, limited social encouragement, programs primarily in English, and lack of exposure to career options (Jennings-Mathis et al., 2020).

Jennings-Mathis and colleagues (2020) also uncovered some levels of microinvalidations in their study. Participants suggested that diversity was not lacking in the profession, and professionals should focus on similarities instead of differences. Others went so far as to call the research about diversity reckless. These sentiments point to a more significant issue of anti-racist beliefs, microinvalidations, and avoiding uncomfortable topics about White supremacy. The counseling profession must discuss complex topics about race and White supremacy, as it plays out in the underlying foundation of many organizations (Brown et al., 2018). Ignoring the issues of systemic racism within the field of EDs limits the growth potential for inclusion and diversity.

Rates of ED in POC

To fully understand the experiences of COCs in EDs, it is necessary to reflect on the increasing rates of EDs in POC. Research in the ED field has primarily focused on European American females (Talleyrand, 2012; Xu & Lee, 2013). With a shift toward all-inclusive diversity research, diversity-relevant publications in the last decade have increased three-fold (Halbeisen et al., 2022). This research developed a more accurate picture of EDs across all

racially diverse populations. As more culturally appropriate research emerged, data indicates that African American and Latina women have binge eating rates comparable to White women, while Asian Americans have similar and/or higher rates of body dissatisfaction than White women (George & Franko, 2010). Binge eating is the most prevalent disorder reported by African Americans and Caribbean Blacks (5.8%), which can be linked to obesity and health issues (Talleyrand, 2012).

Furthermore, African American girls from lower SES groups reported higher bulimic behaviors yet are 75% less likely to be diagnosed with bulimia than White peers (Goeree et al., 2011). This finding starkly contrasts general assumptions regarding the race and income of people who typically struggle with bulimia nervosa. Goeree and colleagues' (2011) study of 2300 girls, ages 10-11, conducted annually for ten years, highlights a disparity between people who show bulimic behaviors and those diagnosed with such behaviors. This disparity, in part, may be due to high-income families of White teenagers with educated parents being more likely to seek treatment and receive a diagnosis of bulimia than African American girls (Goeree et al., 2011).

Though research has increased on African Americans with EDs, Latine and Asian American women are underrepresented in research on the topic (Talleyrand, 2012). One study found that Hispanics are likelier to suffer from bulimia nervosa than their non-Hispanic peers (Becker et al., 2003). In another study, researchers found that Latine people have higher lifetime rates of binge eating disorder (BED) than other racial groups and are at high risk of dieting for fear of being overweight (Rodgers et al., 2018). Asian Americans also reported higher rates of purging, restriction, and body image concerns than their White and non-Asian peers (Uri et al., 2021). Even more concerning is that in a population-based study of approximately 2300 adolescents, Asian American girls indicated the highest rates of disordered eating across all other

groups, including White females (Rodgers et al., 2017). Though many POC suffer from ED symptoms, research shows that they are less likely to be asked about these symptoms by their providers, thus creating a barrier to treatment (Becker et al., 2003).

Treatment Barriers for Clients of Color

Historically, POC have avoided treatment by mental and medical professionals for numerous reasons. Mistrust, lack of accessibility, racial discrimination, sociopolitical histories, and other barriers have led to fewer POC accessing treatment (Talleyrand, 2012; Williams, 2018). For example, though Asian Americans are viewed as a 'model minority', they are still marginalized (Endo, 2015; Xu & Lee, 2013). This marginalization leads to being diagnosed less often with BED due to a lack of presentation of distress and loss of control, as they are culturally unacceptable behaviors required for a diagnosis. Even with a diagnosis, Asian Americans with an ED have lower odds of seeking treatment than non-Hispanic Whites, despite having similar BED prevalence (Lee-Winn et al., 2014).

Additionally, immigration policies can create fear and suspicion in some POC, leading to avoiding mental health treatment for POC who have under-documented immigrant status (Williams, 2018). Other reasons why people with EDs may not seek treatment are shame, minimization of the issue, stigma (Lazare et al., 2021), and institutional barriers such as accessing specialists, long waiting lists, and lack of health insurance (Hart et al., 2011). As racial/ethnic minorities are less likely to seek treatment, healthcare providers must be especially alert to the occurrence of EDs in these populations (Regan et al., 2017). Barriers are breached when systemic change takes place. This change must incorporate more representation in the ED field, cultural competency, and advocacy. Understanding the prevalence of EDs in

racially/ethnically diverse people, along with the value of ethnic matching, informed the need for this study.

Lived Experiences

Counselors in Training

Given that there is no found research on COCs in EDs, it may be beneficial to understand research on COCs in other specialties or settings. Researchers have explored the experiences of diverse counselors-in-training (CIT) in counseling programs across underrepresented groups (i.e., LGBTQ+, women, and African Americans) (Bryan, 2018; Chan et al., 2018). A review of the research by Thacker and Minton (2021) identified eight common themes that fall into two main categories that can capture CITs' experiences: overt microaggressions and isolating consequences. CITs from underrepresented groups consistently reported experiencing microaggressions, including stereotyping, tokenism, erasure, and intersecting marginalization. Facing overt microaggressions, CITs reported experiencing isolating consequences, such as disconnection, mentorship difficulties, discouragement, and pressure of high expectations (Thacker & Minton, 2021). These experiences translate into the workforce as colleagues maintain oppressive behaviors that impede diverse counselors from feeling unified with the collective profession.

Counselors

All counselors will engage with clients from diverse cultural backgrounds. Even within EDs, clients come from varied experiences. One issue Bayne and Branco (2018) found was COC's experiences with broaching. Broaching happens when the counselor is aware of distinct cultural, racial, or other identities and opens a conversation with the client about any concerns. In their study, Bayne and Branco (2018) discovered that COCs were ambivalent about broaching

with White clients. Participants reported high rates of racism and negative client experiences as factors in their ambivalence. Themes from the study showed that when broaching occurred, there was discomfort for the COC, missed opportunities due to discomfort, and second-guessing client behavior. They also found that when a COC was intentional, there was increased comfort with the client, an enhanced relationship, and a better client process (Bayne & Branco, 2018). This study on broaching may connect to the experiences of COCs in the ED as they, too, work with many White clients. Broaching is expected for all counselors as it builds trust, enhances credibility, and offers clients space to explore concerns.

School Counselors

School counselors are another group to consider when examining the experiences of COCs. Dollarhide et al. (2013) conducted a qualitative grounded theory study with school counselors of color (N = 24) in the U.S. Two significant themes emerged: Positive and Negative Racial Events and School Environment. In some positive experiences, participants explained advocating for students, building authentic and credible relationships, and giving voice to students of color. They also described adverse events, like bias, macro/microaggressions, microinvalidations, and disrespect from teachers, students, and administrators. These events led to anger, self-doubt, disempowerment, and erosion of achievement (Dollarhide et al., 2013). The second theme incorporated aspects of the school environment that affect the school counselors' job satisfaction. These were the proportion of racial representation in faculty and students, availability of diverse programs, and administration attitudes (Dollarhide et al., 2013). Counselors specializing in EDs may experience similar positive and negative events to that of school counselors.

Librarians

Given the lack of research on the lived experiences of COCs working in the ED field, examining POC in similar professions can also be valuable. Librarians are one such profession in which the Library Information System (LIS) has extensive research about the experiences of librarians who are POC. The librarian profession is predominantly comprised of White women (Schlesselman-Tarango, 2016), so it may offer a perspective like that of a COC in the ED profession. For example, one author noted, "If we do not learn what being "professional" means from other societal experiences (let's be real, this issue is not unique to libraries), our well-intentioned, White colleagues will quickly inform us. We are often told things like what's considered "appropriate" workwear or to tone down our intensity" (Brown et al., 2018, p.170).

Another sentiment expressed by members of the LIS field is that White colleagues do not want to acknowledge differences or that POC are unable to be authentic in their expressions and way of being. Brown et al. shared that when POC attempt to speak up, others accuse them of making everything about race. However, racism is easy to ignore when the perpetrator is from the majority population (2018). A final experience that may translate to a COC in the ED is how POC may feel isolated in their profession. Brown et al. (2018) explained that being a POC is isolating and lonely in most spaces. When they notice no other POC in the workplace, it reiterates that others see them differently than their colleagues and that diversity and inclusion are still distant goals.

Contextual Theories

In this study, I used the methodological framework of Post-Intentional Phenomenology (PIP) (Vagle, 2018) and contextual theories of Critical Race Theory (Delgado & Stefancic,1998), and Systems Theory Framework (Arthur & McMahon, 2005). In this section, I present

information and rationale for using Critical Race Theory and Systems Theory Framework. Using multiple theories compliments PIP's edict that theoretical frameworks are options for theories the researcher wants to think with, not to narrow the lens of the analysis (Vagle, 2018). Theories offer a launching point for material emerging from data collection. Staying open to other theories that may present themselves throughout research allows researchers to stay true to the principles of PIP (Vagle, 2018). In viewing a phenomenon, multiple perspectives (or theories) can offer a sensible explanation (Anfara & Mertz, 2015). In this study, I considered tenants of Critical Race Theory (CRT) and Systems Theory Framework (STF) as contextual lenses for material analysis. Additionally, CRT informs needed steps to be an ethical researcher.

Critical Race Theory

CRT is a scholarship movement that challenges the premise that Whites establish normative standards through a conceptual framework formed by the experiences of POC (Taylor, 1998). The origins of CRT began in 1970 when Derrick Bell, an African American man, and Alan Freeman, a White man, opined that racial reform was at a distressing slow pace (Delgado & Stefancic, 1998). As other legal scholars shared their frustration, CRT began to take shape as an outgrowth of critical legal studies (CLS). This legal movement challenged liberalism and the blindness of the legal system. However, CLS failed to identify racism as a structure of the legal system; thus, CRT developed to incorporate the issue of race (Ladson-Billings, 1998).

After reviewing prevalent literature on the tenets of CRT, it is clear there are nuanced differences between the original scholars and present-day thinkers (Delgado & Stefancic, 1998; Dixson & Anderson, 2018). As times change and contemporary issues emerge, a single set of doctrines or practices CRT scholars subscribe to does not exist (Ladson-Billings, 1998). As such, this study will use the tenets described by Delgado & Stefancic (1998, 2007) and Ladson-

Billings (1998). CRT postulates the following five concepts; (a) racism is ordinary, (b) interest convergence; (c) the social construction of race; (d) the idea of storytelling and counter-storytelling; and (e) Whites have been the primary recipients of civil rights legislation. Next, I explain each of these concepts more deeply.

The first CRT tenet endorsed by theorists declares that racism is an everyday occurrence experienced by most POC. Racism can be challenging to recognize when it permeates structural and systemic institutions (Delgado & Stefancic, 2007). Through institutions, education systems, hospitals, and other entities, racism becomes so commonplace that "oppression no longer seems like oppression to the perpetrators" (Taylor, 1998, para. 6). This tenet is critical for viewing the experiences of COC and how everyday occurrences of oppression and racism in the workforce shape their lives. As a White researcher, during this study, I continually reflected and wrote in a journal about my behaviors and responses that were possible microaggressions or invalidations that perpetuate racism.

The second tenet, interest convergence, maintains racism to advance the interests of upper-class Whites and the working class (Delgado & Stefancic, 2007; Taylor, 1998). Racial equality only occurs when there is an alignment between the interests of African Americans and Whites. An example of this interest convergence was the recruitment of African American servicemembers during the Second World War. White political leaders embraced the African American volunteers who would fight and die for their country, as it aligned with economic and political self-interests that maintained White privilege. Despite their heroism, they were treated with disdain and disrespect when returning home (Delgado & Stefancic, 2007). This tenet applied to this study's findings.

Furthermore, in reflecting on the interest convergence present in this study, I am aware that in exploring the experiences of COC, I will earn my Ph.D. Thus, by capitalizing on the experiences of COC, I, as a White person, will benefit in imbalanced ways. This notion appears unavoidable but was present throughout the research process. I sought opportunities to maximize the benefits for my participants and COCs as I completed my work.

The third CRT tenet holds that race and differential racialization are products of social thought (Delgado & Stefancic, 2007). Race is not a biological reality but a category invented for particular purposes. Despite studies showing more genetic variation within races, the dominant society racializes different minority groups as shifting needs emerge (Delgado & Stefancic, 2007). Additionally, race is defined by its deviation from Whiteness, which is considered the norm in the U.S. Associating race with only those who are not White allows Whites to treat others based on their race and maintain White privilege (Honma, 2005). This study explored the participant's perception of race as a construct that impacted their work experiences.

As a White researcher exploring the experiences of COC, I was mindful to notice my White privilege. As we are all ED counselors, my initial connection with the participants was about shared professional interests. After establishing rapport, I acknowledged our racial differences and offered them the opportunity to discuss their concerns; many thanked me for conducting the research and acknowledging our racial differences.

The fourth CRT tenet expounds on the need for storytelling and counter-storytelling to offer a medium to share one's own reality (Delgado & Stefancic, 2007). Telling one's story empowers the storyteller and heals internalized demoralization and wounds inflicted by stereotypical images meant to oppress (Ladson-Billings, 1998). This study's purpose was to give a platform for COCs to voice their reality working in the ED field. Given that I identify as an ED

counselor, like my participants, and I identify as White, unlike my participants, I looked for similarities and differences in our experiences that created cognitive dissonance and brought more awareness of how my White privilege has impacted others. This awareness was critical for crafting an accurate text of their experiences.

The fifth and final CRT tenet states that Whites have been the primary beneficiaries of civil rights legislation (Delgado & Stefancic,2007; Ladson-Billings, 1998). This tenet does not suggest that Whites are the *only* beneficiaries but that policies meant to improve equity and access for POC still serve the interests of Whites. This disconnection between purpose and implantation resulted in affirmative action hiring policies benefiting White women at the highest rate rather than POC (Guy-Sheftall, as cited in Ladson-Billings, 1998). I was unable to connect this tenet to the study findings.

Race/ethnicity is not the only factor present in this study. As ED training can be expensive, socioeconomic concerns came about. I acknowledge that my certification comes from dedication but comes first from privilege. Coming from a middle-high income bracket, access to training, books, and certifications was not a financial barrier. I used my Certified Eating Disorder credentials in communications for the study as it established a level of expertise I believed would draw out participants who wanted research conducted with an established ED counselor.

Systems Theory Framework

The Systems Theory Framework (STF) of career development offers a model for viewing the systems that influence an individual's career development content. This theory considers the interplay and relations between many systems of cultural influence (Arthur & McMahon, 2005). The term *influence* reflects the content and processes related to career decision-making.

Individuals ascribe meaning to influences and are encouraged to elaborate on culture connected to their systems of influences. STF encompasses three central systems of content influence:

- Interpersonal (e.g., race, gender, ethnicity, sexuality).
- Social (e.g., values, beliefs, position among family and friends, school, media).
- Environment/societal (e.g., historical oppression, socioeconomic variables, geographic location, and workplace structure) (Lovasz, 2020; Arthur & McMahon, 2005).

Additionally, STF posits three process influences that impact career development:

- Recursive interaction of influences within the individual in context and between the individual and context.
- Change over time, as past experiences shape present influences and the interpretation thereof affect future career outcomes.
- Chance, unanticipated events, as macro systems affect the individuals' systems (Lovasz, 2020; Arthur & McMahon, 2005).

STF accommodates cultural aspects relevant to an individual's career choices. STF legitimizes culture as a critical element of career development by explicitly recognizing content influences. (Arthur & McMahon, 2005). As this study looked at the experiences that brought COCs into the ED field and how they experience the field itself, the recursiveness of STF revealed the relational aspects of career development between individual influences and social-environmental systems (McMahon & Watson, 2007).

STF offers a framework for connecting the complex systems of the participants' lives and compliments the theoretical underpinnings of PIP as the recursiveness of STF mirrors the entanglements and ever-changing connections of individuals with a phenomenon. STF offered a guide for the research question and subsequent research questions that connected to the content

influences of the participants. The content and process influence of STF informed the interview questions. They offered deeper probing into the many aspects of the lived experience of the participants concerning working in the ED field.

Conclusion

Counselors working in EDs are predominantly White (Lundgren, 2022; Jennings-Mathis et al., 2020). This limited diversity presents a barrier for COCs working in EDs due to White invisibility, continued oppression and discrimination, and isolation (Brown et al., 2018; Thacker & Minton, 2021). The homogeneity of the existing field, the ED pipeline, myths and stereotypes about EDs, and unexamined racial bias create issues for the retention and recruiting of COCs (Jennings-Mathis et al., 2020). Personal experience with an ED is one factor that influences specialization in the ED profession. Rates of having a personal experience with an ED can be as high as 47% (Bachner-Melman et al., 2021; Barbarich, 2002; Costin, 2002; De Vos et al., 2016; Warren et al., 2013); yet no study delineates the rate of ED experience with COC, suggesting a potential missing influence in specializing in EDs.

Racial matching in counseling benefits African Americans, Asian Americans, and people of Latine descent (Cabral & Smith, 2011). Additionally, some people prefer to match with their race due to historical oppression (Cofield, 2022). It is essential to recognize the experiences of COCs in the ED field to increase the number of counselors working with this population. As researchers continue to report rates of EDs in POC at rates near or surpassing their White counterparts (George & Franko, 2010; Talleyrand, 2012), the need for more racial diversity in ED counselors is essential for reducing some barriers to treatment. To incorporate representation, we first need to hear and understand the voices of those COC who experience the phenomenon of working in EDs, as I sought to do in this study.

In counseling programs, COC have reported facing microaggressions, such as stereotyping, tokenism, and invisibility, while also facing underrepresentation, discouragement, and disconnection from other students (Thacker & Minton, 2021). These experiences maintain an oppressive environment, impeding counselors from feeling accepted in the profession. As education and training are necessary to specialize in EDs (American Counseling Association, 2014), graduate counseling programs can become a barrier when White standards measure the readiness of POC.

Though PIP utilizes theories to begin a study's design process, theories can change as findings emerge (Vagle, 2018). This study considered CRT to examine the lived experiences of COC working in the ED field. Due to the nature of the study, using a critical theory allowed me to view the phenomenon through a moral lens that seeks human freedom from oppression. When using this theory, I consistently engaged in a reflexive evaluation of my positionality to the study participants and any actions I needed to take to keep the power with the participants and not myself. STF helped me notice connections within the participant's systems that influenced their decision to work in EDs.

Chapter 3: Post-Intentional Phenomenological Research Approach

> *"Phenomenology is a commitment to looking 'at' what we usually look 'through'….to know that our living is always a never-ending work in progress*."
>
> Vagle (2017, p. XII)

In this study, I explored the experiences of counselors of color (COCs) specializing in the eating disorder (ED) field. I used post-intentional phenomenology (PIP) as the methodological framework. Understanding the theory of PIP is valuable in recognizing its similarities and differences with other phenomenological approaches (Vagle, 2018). In this chapter, I first provide a brief overview of PIPs theory, followed by the five components of PIP. I then describe my study's research design, participant qualifications, sampling procedures, material collection, and analysis as they connect to the five PIP components.

Post-Intentional Theoretical Approach

Vagle's (2018) post-intentional phenomenology draws from post-structural and phenomenological philosophies. Post-structuralism ideas resist the notion that a pure experience or structure can represent truth or binary positions, while phenomenology assumes phenomena have an essence or invariant structure. PIP is a marriage between these two schools of thought. Like post-structural approaches, PIP uses the term, *post,* to indicate that phenomenological concepts cannot be defined in a single context. Instead, phenomena are viewed as ever-changing and becoming entangled through time. The term, post, does not refer to the standard definition of *after* or *in opposition to* (Vagle, 2021).

Concerning the hyphen in PIP, Vagle (2018) notes that the use of the hyphen theoretically represents the notion that the work done in PIP "takes place along the hyphen, the jagged edges of phenomenology and post-structuralist ideas … where we enter into middles instead of beginnings and ends" (p.126). There will not be a beginning to the experience of

working in EDs, nor an ending. As COCs continue to choose to work in EDs, they constantly shape and reshape the meaning of the phenomenon and become entangled from moment to moment as they engage with the ED work. Moreover, the phenomenon creates context, and then those contexts recreate the phenomenon (Vagle, 2021). PIP focuses on the way the phenomenon is constantly being made and un-made. In addition, intentionality, tentative manifestations, and epoche are central concepts to PIP, along with the belief that research should focus on social change (Vagle, 2018).

Intentionality

Philosophers such as Heidegger (1927), Merleau-Ponty (1947), and Deleuze and Guattari (1980) use the term *intentionality* to describe the meaningful ways humans connect with the world (Vagle, 2018). Intentionality in PIP does not refer to individuals' subjective intentions but to how people find themselves intentionally being with others in the spaces around them. These spaces must be conceptualized and contemplated and cannot be measured or labeled. The core of intentionality is the idea of connection and meaningfulness of the lived experience. PIP embraces Merleau-Ponty's theory that lines of intentionality connect meaning that runs through relations and is constantly being disrupted, detoured, and reconstructed. PIP acknowledges intentionality is not linear but always moving relationships (Vagle, 2018). As such, multiple inquiry outcomes evolve and shift rather than essentialize.

Tentative Manifestations

Husserl (1900), known as the founder of phenomenology, believed that a phenomenon was *the thing itself*, also referred to as the essence (as cited in Vagle, 2018). Dahlberg (2006) described an essence as the structural characteristics of a phenomenon, which, without, would cease to be that phenomenon. She explained, "essences are not the outcome of interpretation; it is

not the researcher who gives a phenomenon its meaning. Neither are essences, which only lay within the realm of the object itself, ready to describe. Instead, the meaning is disclosed in the researching act that takes place between the researcher and the phenomenon" (p. 12). However, PIP moves away from the concept of essences that attempt to describe what a phenomenon is and instead searches for the connections that take on different intensities across contexts. Instead of an essence, PIP researchers look for tentative manifestations constantly shifting and materializing.

Epoche

To suspend one's judgment allows one to understand the world without pre-conceived ideas skewing phenomenon (Husserl as cited by Vagle, 2018). This suspension of judgment, known as epoche, is accomplished by employing bracketing and bridling skills. Bracketing is standard in descriptive and interpretive phenomenology but is not used in PIP. Instead, the concept of bridling, developed by Dahlberg (2006), complements the theory of PIP more fully. Bridling is like the way a rider navigates their horse. There is give and take with the reins, just as a researcher continually reigns in their biases but allows some room to discover other areas of concern. Phenomenologists attempt to do the same with their judgments. Becoming more acquainted with one's judgments, instead of a one-time declaration of possible biases, allows researchers to continually check themselves and avoid compromising their openness to a phenomenon (Vagle, 2018).

Culture and Social Change

As phenomena are constantly being made and unmade, and researchers are excited to connect with their collaborators, it is critical to be culturally responsible. When using PIP, a researcher must resist using binaries such as right-wrong, normal-abnormal, or politically infused

assumptions (Vagle, 2018). Recognizing that the privileges of White persons are not always afforded to POC, humanity and respect are foremost when conducting PIP research (Vagle, 2021). One final plea from Vagle (2018) is that research should affect social change by disrupting social norms, discourses, and traditions. This study attempted to disrupt the ED field as a predominantly White profession, find ways to encourage more COCs to enter the ED field, and inform counselors and counselor educators how to support COCs and create anti-oppressive learning environments.

Post-Intentional Phenomenological Design

I used a PIP design in this study, explicitly using Vagle's (2018) five-point process for implementing this design. That process consisted of the following components.

(1) Identifying a phenomenon in context around a social change issue

(2) Devising a clear yet flexible process for gathering phenomenological material.

(3) Making a post-reflexion plan

(4) Exploring the post-intentional phenomenon using theory, phenomenological material, and post-reflexion; and

(5) Crafting a text that engages the productions and provocations of the phenomenon in context around a social issue.

Next, I describe the methods employed through these five components of PIP.

Component 1: Identify a Phenomenon in Context Around a Social Issue

Recognizing the privileges and power afforded by a social location and the understanding and insights obtained from that position, can move society towards a more inclusive knowledge system that includes the voices of all racial groups (Honma, 2005). As an ED professional, I am keenly aware of the limited racial diversity in those who work in this field. When considering a

research topic, I felt drawn to know what the experience is like for the few COCs I have met within the ED workplace. This study's research question was: What are the lived experiences of COCs choosing and working in the ED field? This primary question concerns the experiences of COCs choosing to work in the ED field and their experiences while working in the predominantly White specialty of EDs.

Participant Selection

Based on suggestions for phenomenological participant selection (Ravitch & Carl, 2021; Brinkmann & Kvale, 2015; Vagle, 2018), I recruited twelve participants using purposive and snowball sampling for this study. These sampling methods allowed for deep, context-rich accounts of the studied phenomena and are the primary method used in qualitative research (Ravitch & Carl, 2021). Upon obtaining research approval from the University of North Carolina at Charlotte Institutional Review Board (Appendix A), I specifically recruited POC who were provisionally or fully licensed counselors and social workers trained in ED treatment. Their training included employee training, certification training, continuing education courses, reading, and supervision in the ED specialization. All participants were over 18 years of age and signed informed consent. After each interview, I sent the participant a $15 e-gift card. Participants could withdraw anytime but were only eligible for the gift card after completing the study.

To recruit participants, I emailed a call for participation to the Academy of Eating Disorders (AED), the International Association for Eating Disorder Professionals (IAEDP), a database consisting of ED treatment centers in the United States (Appendix B), personal accounts on the social media platforms of Twitter and Facebook, and the counselor education listserv, CESNET. One call for participation garnered twelve people who completed the

informed consent and demographic survey. Eleven of these participants completed both the survey and the interview process.

Component 2: Process for Collecting Phenomenological Material

Following the call by Denzin and Lincoln (2013) to shift the term *data* to *empirical material*, Vagle (2021) noted that this shift distances us from positivism and allows researchers to think more broadly and creatively about what constitutes the materials gathered. Phenomenological research often utilizes interviews for material collection. Interviews are opportunities to learn in-depth, meaningful, and exciting information about the phenomenon from each participant (Vagle, 2018).

In this study, after sending out the call for participation, potential participants accessed a Qualtrics survey through a link in the email. Once in the survey, they read the consent form and agreed to participate in the study (Appendix C). After consenting, they completed a short demographic survey (Appendix D). In addition to the demographics, participants assigned themselves a pseudonym and indicated an email for further communication. Once I obtained the affirmative consent and email, they scheduled themselves for the interview using icalendy.com. We met for the online interview through Zoom, an online synchronous video platform.

The interviews lasted approximately one hour; follow-up interviews were not necessary. Though Vagle (2018) suggests multiple forms of materials enhance connections between the phenomena and the participants, an interview was my only source of material. After identifying a line of flight from the first two interviews, an additional question was emailed to nine participants. Three participants responded to the emailed question, “Did your ED professional experiences influence your decision to enter a doctoral program? If yes, in what ways? If not, will you incorporate ED in your research and teaching?”

Though unstructured interviews are popular in phenomenology, as they tend to be more open and conversational, having little to no guiding questions can lead to speculation and losing focus on the investigated phenomenon (Vagle, 2018). Even with an interview protocol (Appendix E), my first interview became unstructured, and once I began the analysis, I understood the danger of losing focus. The following post-reflexion highlights my internal struggle with beginning the interview process. Per PIP, post-reflexion entries are positioned throughout chapters three and four to demonstrate my connectedness to the research process and phenomenon.

Post-Reflexion Journal Entry November 1, 2022

I didn't need to follow much of my interview protocol as Amelia touched on almost everything I was going to ask. I felt like I just wanted the conversation to go wherever they took it and I think that went better than asking each question. However, working on the analysis for Amelia left me uncertain of how to analyze through a PIP framework. It also showed me that I might not be focused enough on the phenomenon with my questions. What is the phenomenon exactly? The experience of choosing EDs, the experience of being in the ED workspace- does this include clients or just other professionals?

After this interview, I attempted to maintain the semi-structured interview protocol as a guidepost to keep the focus on the phenomenon and allow for flexibility with follow-up and probing questions. These questions allowed participants to elaborate or extend their answers through the curious attitude of the interviewer (Brinkmann & Kvale, 2015). Interviews are snapshots of the participant's experiences they can recall at the moment. These experiences are subjective and can change throughout the phenomenon. As the interviewer, I became part of the retelling of their stories. Being a White woman has some bearing on what they felt safe to share, their language, and how deep they were willing to go with personal accounts of discrimination. During multiple interviews, I attempted to bridle my belief that participants were self-censoring;

however, I felt there was a hesitance to admit they had faced racism in the workplace. One post-reflexion journal entry captures this thought:

Post-Reflexion Journal Entry September 21, 2022

Going into the interview I had some thoughts that it would be similar to the first interview with Amelia. However, Jade presented a more positive experience with working in EDs. She focused on the good things and said limited comments about White colleagues or negative experiences. I kept thinking either she had only great people or she wasn't sure she could share with me. Towards the end I asked if she had ever felt oppressed in EDs, and she said she didn't know. She got quiet and thoughtful, and I think she honestly didn't know. I wondered about her identity development level. Through the conversation I could feel myself being unsure because she wasn't sharing the experiences, I thought she may have had, which made me focus more on what she was saying and just delving deeper into her narrative instead of what I thought would come out.

Part of PIP is the intentionality between the interviewer and the participant. My connection to each participant varied; however, my goal was to offer a space for them to share their stories with unconditional positive regard, curiosity, and validation. Regardless of what the participants shared, my role is to be non-judgmental and person-centered.

Trustworthiness

Quality in research depends on a researcher's approach to establish each study's rigor. Validity, used in quantitative research, is expressed as trustworthiness or credibility in a qualitative study (Hays & Singh, 2012). Establishing trustworthiness is achieved by systematically implementing standards that improve the study's rigor. Ravitch and Carl (2021) suggest multiple methods research projects can follow. This study employed credibility, transferability, and a transformative approach.

Credibility

Utilizing a recursive design allows a researcher to establish credibility (Ravitch & Carl, 2021). Credibility is a researcher's ability to manage a study's complexities that may be beyond

the researcher's understanding. This study's strategies for increasing credibility were member checking and peer debriefing.

Member checking, also known as participant validation strategies, allowed participants to review the interpretation of findings and how they felt about the material pertaining to them (Ravitch & Carl, 2021). Member checking is crucial for establishing credibility because it helps ascertain whether I understood and interpreted participants' responses accurately (Hays & Singh, 2012; Ravitch & Carl, 2021). Including participants in constructing meaning within their lived experiences and clarifying accuracy from the information gathered in the interview increased accuracy and supported cultural humility. Within the interview, checking is accomplished with probes and clarification questions (Ravitch & Carl, 2021). After the interview, I contacted participants a second time for the option of reviewing their transcripts. Two participants returned their transcripts with edits. Once tentative manifestations emerged, participants were sent an email with these findings and the invitation to give feedback through email. No edits were returned, but two participants shared their excitement about the completion of the study.

The other method for improving credibility is the use of peer debriefing. Like member checking, peer debriefing must include a rationale for selecting peers (Mertens, 2020). In this study, I engaged in two peer debriefs after the interviews, with short conversations throughout the interview process about what I was feeling and any responses I felt could give clarity and help me bridle any judgments I was feeling. Utilizing this method during the interview process allowed my peer debriefing with me to pose questions that improved the subsequent interviews. Additionally, these checks offered the opportunity for feedback about possible racial harm or biases that I was unaware were occurring during this phase of the study. This feedback included suggestions for changes to tentative manifestations considered unfavorable or deficit-based. To

be culturally competent, I sought peers in my cohort that are POC to debrief with me—understanding that it is not their job to teach me to be culturally sensitive but to ensure safety for the participants and to improve the richness of the responses.

Transferability

As PIP describes phenomena as being in flux and ever-changing, transferability is not a goal for this theoretical framework (Vagle, 2018). However, achieving application of findings to a broader context can be achieved by using thick descriptions (Ravitch & Carl, 2021). In qualitative research, the reader must make connections between the study and other contexts (Mertens, 2020). The researcher's onus is to deliver a detailed description of various aspects of the phenomenon, including time, context, culture, and place, offering a thick description (Mertens, 2020). Formulating focused questions that allowed for deep and wide responses created the thick descriptions captured in this study.

Transformative Approach

Mertens (2020) explained that the transformative approach is situated to encourage social justice and human rights. Using transformative criteria leads to authenticity and a type of multicultural validity. Using reflexivity, reciprocity, and a research purpose focused on social change, this study aimed to meet the standards for transformative research. Further in this chapter, I present my reflexivity statement, and the research purpose was explicated in the previous section. My plan for enacting reciprocity is to use this study to develop a research agenda focusing on increasing COCs in the ED profession. Additionally, findings from this study can inform counselor educators and leaders in ED professional associations about the barriers that still exist and open the dialogue for actionable changes in the ED profession.

Material Sources

Post-Reflexion Journal

Reflexivity is when the researcher examines how their positionality, worldview, background, and knowledge influence every aspect of a study (Vagle, 2018). Post-reflexivity comes from descriptive phenomenology's term of bracketing, defined as suspending one's judgments or pre-conceived ideas in relation to a phenomenon. Post-reflexivity also extends from Dahlberg's (2006) concept of bridling, which encompasses bracketing and posits a reflective attitude that allows for easing the intentional threads that connect us to the world. Post-reflexivity does not ignore our prior understanding, assumptions, or beliefs but explores how they intertwine with producing the phenomenon. (Vagle, 2018).

As post-reflection occurs at all points during the material gathering, it was chronicled throughout the research study and recorded in a journal. The material analysis includes the writings from this journal. Entries focused on moments of connection or disconnection with what was being said by participants. Additionally, I journaled my assumptions of normality and beliefs or perspectives I was hesitant to change. Lastly, I recorded moments of shock, personal questions, personal contradictions, and general thoughts about the process (Vagle, 2018). These entries are placed throughout this paper and in the previous sections.

Interviews

In this study, the first source of material came from a Qualtrics survey that contained the consent form and the demographic questions. Demographics gathered through the Qualtrics survey were race/ethnicity, gender, and if they have had a lifetime ED diagnosis. Participants indicated their level of completed education, the title of degree, years working in the ED field, type of ED training, and type of environment they practice. The next source of material was the

interview. I began interviews by reviewing the consent form and explaining a brief overview of what to expect in the interview. Initially, I did not broach my Whiteness. After speaking with my peer debriefer, she encouraged me to broach race. This critical change allowed the participants to share their thoughts on my Whiteness related to this study and ask why I wanted to conduct a study on COCs. A couple of participants encouraged me to continue this work and were excited to see what comes from their interviews. This change also allowed me to get out of my head about what they must think about me being White and if they wanted to end the interview as soon as they saw me. After the broaching, I continued to conduct a semi-structured interview with participants.

Studying phenomena calls for examining individual experiences of the phenomenon. As the primary phenomenological question attempts to identify the phenomenon, crafting secondary questions can focus material collection on the primary research question (Vagle, 2018). This study's primary research question states: What are the lived experiences of COC choosing and working in the ED field?

The following were the secondary research questions.

- What factors lead a COC to work in the ED field?
- What are the experiences of working in the ED field?
- What are your experiences of being a COC working in the ED field?

For the full interview protocol, see Appendix E. However, after the first interview morphed into a more authentic conversation, the interview protocol became more of a guidepost. After the interview, participants were thanked for their time and informed of the next steps of member checking and completing any follow-up questions. Upon completing the interview, I sent each participant a $15 e-gift card to thank them for their time.

Component 3: Post-Reflexion Plan

Post-reflexion is not about removing our assumptions or knowledge about the phenomenon but understanding our role in producing the analysis of the phenomenon. (Vagle, 2018). Post reflexion is an ongoing process chronicled in a journal throughout the study; the journal becomes part of the analysis. As this process started at the beginning of the study, next is my initial post-reflexion. My initial reflections on engaging in this study begin with the following experience.

Post-Reflexion Statement

As a White woman, I have felt unsure about my lane in researching the experiences of POC. After sending out requests for participation, I received a response that almost ended my research before it could begin. The author wrote:

> You mentioned there are not enough counselors of color researching for this topic to be represented. I think that it could be helpful to understand the conditions that contributed to this issue and continually ask if this field needs another privileged voice spearheading this work. With the popularization of anti-racism, many white researchers, authors, and practitioners are finding that they are encouraged to build their careers and social status off of the experiences of those who experience racial oppression while still taking up space from the people who need to be centered. It avoids the real work that needs to be done by those with racial privilege, which is contended with the construct of whiteness and working to understand how it has been personally and culturally embodied and working to dismantle it within every area of society, including mental health and eating disorders.

This response evoked strong emotions of hurt and disbelief. I thought, "They do not know me. They implied I have no integrity and would use others for my benefit." This response was the exact fear I had in choosing to conduct research outside my own identity. Being a person of racial privilege, I acknowledge that researching POC will be impacted by my race and can be construed as using White privilege to elevate my career. I do not want to take from POC more than my White privilege already offers me. Am I using this population for selfish purposes? Could I have chosen a White cohort to study? Am I authentically concerned about the experiences of my COC colleagues? After this study, what am I willing to do to exact changes to the potential discoveries of perpetual racism and White oblivion?

Not using my social location and privilege to research underrepresented groups is what Hill Collins (2002) identifies as "suppression" and "paying lip service to the need for diversity" (p.6). Due to these concerns, I discussed my motivations with POC in my doctoral cohort and on my dissertation committee. They offered feedback about the importance of this study and noted that until there are more POC in the field of EDs, it is my responsibility to do research that can contribute to needed awareness in this field. My first post-reflexion below comes after this email and subsequent discussion.

Post-Reflexion Journal Entries October 10th and 19th, 2022

I am excited to have two potential participants! I have felt insecure about this study and overwhelmed with the possibility that no one will want to take part. Will other people feel negative about me like the author of the email?
Today was my first interview. I explored what knowledge and preconceived ideas I might have before interviewing and took note of my thoughts they would not be as open with me because I am White. Already I feel better as the first respondent thanked me for wanting to do research on POC in EDs.

The first two participants' support shaped how I engaged with them and subsequent participants. As phenomena circulated through social relations, I became part of the phenomenon

of working in the ED field. Despite the oppression the first COC endured in the White spaces of EDs, they allowed me into their life space. This acceptance, which my participant did not always receive from White colleagues in their places of work, gave more intentionality and shaped our experience of the phenomenon.

As a certified ED specialist with eight years of counseling experience, I have noticed the limited racial diversity among ED counselors firsthand. As most ED counselors look like me, I have critically examined how that uniformity weakens our profession. This limited racial diversity concerns me because a potential lack of access to other racially diverse counselors, absence of lived experiences and knowledge from COCs, and limited awareness of needed cultural changes have an adverse impact on the field. In my eight years of clinical experience, in which I treated hundreds of ED clients, I treated only nine POC with EDs. This number elicits two strong feelings: embarrassment and fear. I feel embarrassed that I did not advocate or position myself in places of visibility for POC. I ignorantly assumed that few POC were seeking treatment or preferred a COC. I feel afraid that many POC do not realize they might have an ED, that physicians are underdiagnosing them, and that POC will not get the needed ED treatment. As a society and profession, I fear we are not doing enough to educate people on the prevalence of EDs in all races and ethnicities or how to identify the symptoms.

Cultural humility and cultural competence are values I ascribe to; moreover, there is an ethical obligation to increase the number of racially and ethnically diverse counselors in this specialty. This desire to increase representation in the field manifests in this study. Throughout this study, I sought to maintain cultural humility. I attempted to build a safe environment and reassure participants of their power and control in this study and how the findings can benefit POC. I frequently examined my questions, beliefs, biases, and responses to be consciously aware

of any unintended harm I may inflict on participants. I acknowledge that because I am White, COCs may have chosen not to participate in the study. Those who participated may hesitate to be honest about how White colleagues have treated them. My race may also limit their trust and willingness to be open with me, impacting the comprehensiveness of this study. With this study, I hope to exact change in the profession and bring more visibility to the need for COCs to specialize in EDs and the burdens placed on them by working in White spaces.

It is also important to consider my experiences with EDs when embarking on this study. Though I have not personally had an ED, my sister had anorexia nervosa for many years, and I struggled to understand her and how to help her. When offered the opportunity to train in this specialization through an internship in my masters counseling program, I quickly accepted so that I could help families support their loved ones with EDs. Conducting research in this area allows me to add knowledge to the field of EDs and indirectly help more people overcome their EDs.

Component 4: Exploring the Phenomenon

When crafting a PIP study, selected theories should fit well with the anticipated phenomenon. However, these theories may change after gathering the phenomenological material (Vagle, 2018). During the analysis phase, the theory can help extend knowledge, offer a critical lens, and inform what you notice. I used Systems Theory Framework in this study to guide the questions and CRT when deemed appropriate.

Phenomenological approaches often use whole-part-whole analysis and synthesis (Vagle, 2018). This method utilizes the idea that researchers must think about moments in relation to the broader context of the phenomenon. Then as parts are removed from one context and dialogued with another, new analytic wholes create meaning in relation to the phenomenon (Vagle, 2018).

In this study, the first step of component four was a holistic reading of their interview transcript. This overall reading allowed for attunement to the whole event. Next, I conducted a line-by-line reading with detailed notetaking and marking content containing initial meaning. After this initial notetaking, I crafted one follow-up question for doctoral participants about if or how ED work influenced their decision to enroll in a doctoral program.

The following steps were second and third line-by-line readings to continue articulating thoughts and finding connections across participant responses. These connections, or tentative manifestations (Vagle, 2018), are similar to what other researchers call ‘themes’ or ‘essence.’ Though essence clarifies the phenomenon, researchers should be mindful that the connections and intentionality belong to the phenomenon, and we do not create meaning for the phenomenon (Dahlberg, 2006). I physically laid out tentative manifestations printed on paper to offer a better understanding of how they would connect across participants. See Figure 3.1 below.

Figure 3. 1

While deconstructing the whole-part-whole method, Vagle (2018) used Deleuze and Guattari’s (1987) philosophical idea of lines of flight. Lines of flight incorporate two analytical processes; looking for ways knowledge takes off and veering from assumptions. Knowledge

takes off by asking, “what feels out of place? And “what might I learn about the phenomenon outside my experience?” (Vagle, 2018). Furthermore, lines of flight challenge the thinking of where I appeared confident of meanings, retreating to either-or thinking or feeling uncertain about the meaning of contradictory findings. As lines of flight allude to how post-intentional phenomena flee and change course (Vagle, 2018), this analytical process acknowledges a multiplicity of connections and manifestations that may come from this study that is not limited to my findings.

Lastly, I examined the written responses from those who answered the post-interview email question, personal edits to their transcripts, and my post-reflexion journal similarly to the whole-part-whole method. Material from the interviews and theory offered more complete insight into the connections between me and the phenomenon. These reflexions offered insight into the beginnings of assumptions, connections, and interpretations. These initial starting points allowed for unpacking reflexive thinking about how I shape and produce the phenomenon (Vagle, 2018).

Component 5: Craft a Text that Engages the Productions and Provocations of the Post-Intentional Phenomenon

Crafting a text that engages the production and provocations of the phenomenon is the final two chapters of this study. In the next chapter, participants' stories connect through the phenomenon. I will look for intentionality within their experiences of being a COC working in EDs and how I become part of this phenomenon. When looking at the material, it is ideal to seek out provocations. Vagle (2018) describes a provocation as a more intense catalyst. There may be a participant response that ignites something about the phenomenon, or current events in the world may reshape their experience with it. Productions are ongoing ways the phenomenon

shapes over time. In the analysis, paying attention to these provocations and productions may be essential for producing social change (Vagle, 2018).

Summary

In Chapter Three, I explained this research study's methodology. The studied phenomenon was the lived experiences of COCs working in the ED field. This study filled a gap in the research on the experiences of COCs working in the ED field. I used a PIP design to guide the study, and the methods used aligned with the five components of PIP. Material for this study was collected through in-depth, semi-structured interviews and a post-reflexion journal. Trustworthiness was established through member checking and peer debriefing. The material was analyzed through the whole-part-whole method and line of flight concept by Deleuze and Guattari (as cited in Vagle, 2018). Throughout the analysis process, I was open to different theories, including CRT and STF, to analyze manifestations and meanings discovered through the material.

Chapter 4: Intentionality and Material Analysis

"*There's really no such thing as the 'voiceless.' There are only the deliberately silenced or the preferably unheard.*"
— Arundhati Roy, Sydney Peace Prize

When crafting the text for presenting findings, Post-Intentional Phenomenology (PIP) is not organized like descriptive (structures) and interpretive phenomenology (themes). Rather, Vagle (2018) encourages the writer to organize the writings in the way it best communicates the intentionality of the participants with the phenomenon regardless of commonly espoused writing structures. Findings for this study incorporate long block quotes with connections to the participants and me, written narratively.

In alignment with the reflective nature of PIP, before you, the reader, begin this chapter, I encourage you to take a moment to consider your preconceived ideas and stereotypes about eating disorder (ED) work. As you read, allow the experiences of these counselors of color (COCs) to flow within you and begin to shape a new understanding of what it is to be a COC working in the ED field. You should not come out of this chapter the same as you began. This change is the intentionality of PIP.

I appreciate PIP's permission to acknowledge my connectedness to the phenomena (Vagle, 2018). In Critical Race Theory (CRT), the tenant of counter-storytelling is critical to hearing accurate portrayals of the experiences of POC (Ladson-Billings, 1998). Through counter-storytelling, the COCs in this study shared their stories with me, trusting that I would tell their truths. In this chapter, I attempt to weave the experiences of the COCs with my post-reflexions, demonstrating how phenomena ebb and flow. Through post-reflexion, I have explored my lived experiences in relation to the phenomena and found meaningful connections and places where our experiences converge and diverge. As a reader, you are now part of this

phenomenon, and how you choose to let this information shape you is the first step to social and systemic change.

Participants

CRT includes storytelling to empower the oppressed and heal internalized wounds (Delgado & Stefancic, 2007). Before finding lines of flight or looking for intentionality, per PIP analysis, I will introduce the participants that shared their stories with the expectation that change can begin within the ED community. Each person is more than their demographics; however, starting with those identities offers us a lens to see the diversity of the participants and then make connections.

Amelia

Amelia is multiracial, with Asian, Cuban, and White heritage. Their pronouns are they/them, and they identify as genderqueer. Amelia is a Licensed Clinical Mental Health Counselor Associate and is currently in a counselor education doctoral program. They are passionate about EDs and working with "folx" with disabilities from marginalized populations. Amelia worked in a college counseling setting for three years, specializing in EDs and running an ED support group. Amelia shared that having an ED in their childhood led them to work in the ED field.

> I had a history with eating related disorders and concerns. And I remember not getting the same treatment as white folks would get … My eating disorder was contributed to systems of power, particularly white supremacy culture … I knew I didn't want to go back and continue treatment because of how the psychiatrist spoke to me and treated me. My experience inspired me to work with folx with eating related concerns and body

image distress … I think as simple as it happened to me. And I don't want it to happen to anyone else.

Jade

Jade is a Black female and uses she/her pronouns. She is a Licensed Clinical Mental Health Counselor and is currently in a doctoral program for counselor education and supervision. Jade describes herself as a spiritual person who enjoys teaching yoga and connecting with people. Jade reported that she began her work with EDs by happenstance. With the encouragement of a supervisor and a chance conversation with a friend working at Veritas, she began her work with EDs. Jade worked for five years in an inpatient hospital unit for EDs. She has experience with EDs at all levels of care and said she loves her patients. Even when faced with the obstacles of treating EDs, she shared, "there is an avid member in me. I don't see myself going anywhere."

Dee

Dee is a Black female and uses she/her pronouns. She is the only Licensed Clinical Social Worker participant in this study and has been working with EDs for ten years. Dee works at a hospital outpatient ED clinic and owns a private practice. Dee found her way into the treatment of EDs during her internship rotations at a hospital. She said, "I floated over to the inpatient eating disorder unit, and I remember this seemed interesting compared to other units. And something about it kind of feels like I should be here. Like it feels like it makes sense."

Esmeralda

Esmeralda is a Latine female and uses she/her pronouns. She is a Licensed Clinical Mental Health Counselor and is currently in a doctoral program for counselor education and supervision. Along with teaching in her doctoral program, she maintains a private practice of

clients through telehealth and has worked with EDs for about five years. Her journey into EDs came when a professor specializing in ED treatment became her supervisor, and Esmeralda discovered her struggles with food. She shared:

> So little by little, I felt very drawn into that specific work. Once I graduated, this professor hired me to work with them. So, a little bit of happenstance, a little bit of personal experience. And the more I learned about it, the more I learned that we don't talk enough about it. And also, there's just not enough clinicians out there who treat eating disorders … It is really hard. It's very scary, but I just keep coming back to it. I keep coming back to it.

Brianne

Brianne is a Black Indigenous female and uses she/her pronouns. She is currently in a doctoral program for counselor education and supervision and is a Licensed Clinical Mental Health Counselor. Brianne has been in the ED field for a short time but moved quickly into the role of program director at an ED clinic and is now working at an outpatient clinic while in graduate school. She shared that her path to ED work came from personal experience.

Presley Marie

Presley Marie is a Hispanic female and uses she/her pronouns. She is a Licensed Clinical Mental Health Counselor, a doctoral student in counselor education and supervision, and the owner of a private practice. Presley Marie has been working with EDs for seven years and began her work at a treatment center. She is currently training to become a Certified Eating Disorder Specialist. Presley Marie experienced an eating disorder throughout her youth and saw both parents struggle with eating concerns. She wanted to avoid EDs in counseling but reported that ED clients kept coming to her. She explained:

> So, my own personal struggle, I've been in recovery for many years … I always said I wouldn't, I wouldn't treat this diagnosis just because it's so hard and challenging and complex. I wanted to avoid them completely … It was like, I don't want to be sitting with somebody that is either myself or my mom. And then, in my internship, I kept getting cases that were eating disorders. I'm like, why do I keep getting these? And nobody wanted to touch them, and it was like, okay, I'll do one, I'll do two. And then it just kept coming. I was like, okay, I get it. I'll just specialize in that. But I really love what I do.

NK97

NK97 is an Indian female and uses she/her pronouns. Like other participants, she is in a doctoral program for counselor education. Her research area is international transgender care for eating disorders, and she feels strongly about helping South Asian clients. She is a resident in counseling and has worked with eating disorders for three years at the intensive outpatient level. Choosing to work with EDs came as she looked for work after graduation.

> I was so anxious after my master's looking for a job. I just didn't know what to do next. I got this job known in the area for eating disorders, and when I started doing it, I realized it just made sense to me because I grew up with a mom who's always struggled with eating concerns and body issues.

Mary

Mary is an Asian female with a Ph.D. in counselor education and supervision. She has 17 years in the field of EDs and currently works on a college campus. Her professional experience with EDs extends from community mental health and assisted living centers to college counseling centers. She chose to focus on EDs due to her personal history with the disorder. Mary openly shared, "I myself had issues with binge eating and being overweight and being

body shamed." This experience, though painful, influences her work with clients. "I can help my clients based on my experience, my journey. That was very empowering, very powerful, and very meaningful."

Miranda

Miranda is a biracial Black cisgender woman that uses she/her pronouns. She is a Licensed Clinical Mental Health Counselor and school counselor enrolled in a doctoral counselor education and supervision program. Miranda has ten years of experience working with EDs and started her journey working in a hospital inpatient ED unit. Though her role as a school counselor is primary, she remained at the hospital working with EDs for patients of color. She works as a school counselor during the week and at the hospital on the weekends. She noted:

> There were no Black staff. There was nobody that represented our patients, anybody that looked like them. And I think for me, that was something that kind of grew to be important as I thought about the people that I worked with and how much some of the Black patients would gravitate toward me.

Ellie

Ellie is a Latina female whose parents are from Bolivia and El Salvador. She uses she/her pronouns, identifies as queer, and is a first-generation student. Ellie is a Licensed Clinical Mental Health Counselor and is currently in a doctoral program for Counselor Education and Supervision. She has worked in the ED field for almost three years at an ED treatment center in partial hospitalization, intensive outpatient, and outpatient levels. She chose ED work due to personal experiences. She explained:

> I had my own eating disorder in middle school until the end of my time in undergrad. I was really interested in ethnic identity and how that plays a role in body image. I wanted

> to help other people because eating disorders aren't well-researched for us. There are not a lot of specialists out there, and I feel like it's one of those gatekept subsections of mental health and I don't understand why because it's one of the most lethal mental health diagnoses.

Tanesha

Tanesha is a Black female and uses she/her pronouns. Like the other participants, she is a Licensed Clinical Mental Health Counselor currently in a doctoral program for counselor education and supervision. Along with school, she has a private practice that primarily caters to Black women with EDs and mood disorders. Tanesha did not seek out ED specialization; she shared, "actually I kind of just like stumbled into working in eating disorders." Her internship at a college counseling center afforded her the opportunity to be hired and begin working with the ED treatment team. Though it was not initially a deliberate choice, she shared her thoughts about continuing to choose this work:

> So even though it's hard to do and it can be very emotionally draining, I find it valuable work. I can help give voice to a community that hasn't had a voice because of stigma and because doctors don't believe that it's possible for Black folks to have eating disorders when they can.

Component 5: Craft a Text that Engages the Productions and Provocations of the Post-Intentional Phenomenon

When using PIP, the concept of "through-ness" eliminates a linear relationship between subjects and the world. Through-ness conceives that meanings are generative and produced in the process of their living out (Vagle, 2018). Working in the ED field as a post-intentional phenomenon is shaped, provoked, and produced by the COCs. Reciprocally they are reshaped by

the phenomenon. This shaping is through their work with clients, the environments in which they work, the social narrative about EDs, the way their colleagues treat them, and their communities, to name a few.

Within the shaping of the phenomenon, I searched for tentative manifestations, which are connections that take on different intensities across contexts that shift and materialize but do not assume there is an essence to the phenomenon (Vagle, 2018). Provocations and productions are also identified and explained further in the chapter. Within this study, there arose six tentative manifestations; *unprepared*, *isolating spaces*, *unspoken knowing*, *sense of duty*, *exhaustion*, and *microaggressions*; five provocations; *vulnerability*, *race as an asset*, *complexity*, *double bind*, and *credibility*, and two productions; *cultural inclusion* and *why we strive.* As I present these findings, my intentionality with the interviewees and the phenomenon is woven into this production, partly through personal reflections and excerpts from my post-reflexion entries.

Post-Reflection Entry Jan 3, 2023

After reading through all the transcripts, I feel overwhelmed with all the experiences and knowledge these participants shared. The responsibility to tell their story weighs heavy on my shoulders. How can I do their stories justice without printing every word they spoke?

Tentative Manifestations

Unprepared- You Don't Know What You Don't Know

For some participants, the path to the ED field began from personal experiences with the disorder. For others, it became a reality after graduate school. For all participants, graduate school was described as disconnected from EDs and offered little opportunity or education. When exploring experiences in their counseling graduate program, participants unanimously agreed that EDs were inadequately discussed. Responses were short when I asked participants if they were encouraged to complete their practicum or internship in an ED setting or what they

learned about EDs in their counseling training program. Participants answered “no,” “nothing,” or, as Brianne noted:

> We had one [undergraduate] class, not a semester [course], one singular class on eating disorders. And in my masters, there were no classes on it unfortunately. And so, it was a huge onset journey in my residency learning about eating disorders. … How can something that’s affecting millions of people, one of the most fatal mental health diagnoses not be talked about in a clinical mental health program?

Though most participants shared similar concerns about the absence of ED education in graduate school, Amelia’s experiences added an unexpected provocation from their professors. They stated:

> When I talked about wanting to work with college students with eating related concerns, it was crickets … And I always felt so confused about that. Like, am I in the wrong profession? Do I need to be doing something else? And I just did not get the support. And then, you probably heard the same thing, is this is for psychology majors, these are for clinical psych students. And I’m like, what? Why does there need to be a separate discipline to be working with this population?

As strongly as Amelia wanted to help clients with EDs, they received a message that EDs are not disorders counselors treat. Professors who believed ED treatment belonged to psychologists challenged Amelia’s connection to their professional identity. This dismissal of Amelia’s desire to connect with people struggling with EDs could have disrupted their path to choosing and working in EDs.

With no more than a single class lecture on EDs and only one participant who reported having a supervisor in graduate school that knew how to support her working with ED clients, these COCs felt unprepared to transition into the workforce. Esmeralda shared:

> It was very scary to me mostly because, I didn't know what I didn't know. We weren't really taught about eating disorders. And so, it was a lot of, I don't even know where to start, like, what books do I start reading about? Then it was like, what podcasts? Yeah. I think it was a lot of anxiety in the very beginning.

As she spoke, I recalled myself as a new counselor, thinking I needed to buy every book written on EDs to be less anxious. My connection with Esmeralda tightened as I sensed we both experienced the fear of treating a complex disorder with limited knowledge. For each COC in this study, the level of training provided in graduate school and at their place of employment impacted their transition into the workforce.

As I asked NK97 about the challenges of moving from graduate school to ED work, she replied, "Yeah, I was scared … And it was really scary in the beginning … Like it was super intense for somebody who just started being a counselor out of school." This intensity might have been more than a new counselor could handle with the limited knowledge received in graduate school. Unfortunately, even after graduate school, some participants shared the continued lack of access to training. Dee shared:

> Maybe around six years being on the unit is when I did CBT training, I mean, I think it's really ridiculous. I think it should be mandatory to have some level of training … But I feel like there's a lot of people who don't want to work with this population and may not get it and it could actually be kind of harmful to patients and treatment … if you're going to work on that unit, there has to be some training.

As a certified eating disorder specialist, this experience for Dee astonished me. Treating clients at the inpatient level of care and not knowing how to offer appropriate treatment had been terrifying for her. Other COCs in this study also relayed not having training until years after they began ED work or seeking training on their own if they wanted any training or supervision.

Though we do not consider beginnings or endings in PIP, in reality, many of these COC embarked on the edges of the ED field as they entered graduate school. Some were unaware of EDs, others had life experiences with EDs, and others learned in a single lecture or when treating a client in practicum and internship. Regardless, graduate school played a critical role in the beginning stages of their career in the ED field.

Isolating Spaces- Making a Seat at the Table

In phenomenology, the threads that connect an individual to the world create a sense of meaning (Vagle, 2018). Working in EDs requires collaboration, which brings joining or separation among colleagues. As we explored the experience of White spaces, a shared feeling of isolation and not belonging emerged. Though White spaces in the ED field can offer a supportive environment, most participants in this study reported that they did not perceive a welcoming space where their concerns about cultural treatments or knowledge of POC were heeded or appreciated. After exploring their lived experiences in ED work, I could see how their intentionality to the work ebbs and flows, is made and unmade in relation to their identities as COCs (Vagle, 2018).

Amelia, who purposely searched for ED internships and employment, described their connection to their White colleagues as professional, but their desire to grow the Black, Indigenous, People of Color (BIPOC) community as strong. They said, “I want to be in a space where there’s other clinicians of color who are passionate about working with other marginalized

folx who are coming in with eating related concerns." Though they worked with many different mental health professionals, they were generally the only COC. Amelia said it "felt exploitive" when constantly called upon to treat clients of color and to educate other clinicians about cultural issues.

When looking at Dee's experience working in EDs, she struggled with a sense of belongingness and concern that there was no space for voices of color. She explained:

> Being the only counselor of color has made me feel that like I don't belong there. Like I shouldn't be there. And I know that's not true, but the initial thought is maybe there's not many of us because we shouldn't be here or because we should be doing different type of work. Then it makes me question, well, was there a space to invite other clinicians of color in or opportunities to share information about the eating disorder population with minorities?

Dee's initial thought may stem from the systemic oppressive messages that Black people do not align with specific careers or professional spaces (Ferguson & Dougherty, 2022). She later expounded that her feelings in these professional spaces may mimic what POC encounter when they look for ED treatment or wonder if POC can have an ED. She considers the foundational question of who decides who belongs and whether there is a place for her community.

One final statement that struck me as essential to understanding isolation in the experience of COCs in the White spaces of ED work came from Esmeralda.

> The whole room was full of what seemed to be very thin White women. And I remember feeling so isolated in that room. And there was something about it that just didn't, I didn't feel like I belonged there. I felt when I went into spaces like "what about my people?" for example. Or think, "what about Latine communities"? Are we

> having conversations about how we're making treatment more accessible for undocumented communities? Just feeling very isolated, having to be the spokesperson for that population…Or it almost feels like I have to make space for my own voice. I have to make space for very nuanced questions that I ask related to culture.

Esmeralda connects to her community and deeply desires to be part of the ED field, but in a field considering Latine people's needs. She makes space for her voice; however, to be the single voice without others' support pulls at her sense of belonging.

The intentionality we initially shared as doctoral students began to ebb and flow as I instinctively connected and disconnected to their experiences in the workforce related to being a COC. As I listened to the COCs share about their places of work, the prevalence of this tentative manifestation, despite interview context based on relationship dynamics, reflected openness and a willingness to trust me with their stories. Opposing feelings of guilt and relief emerged with each participant based on how White colleagues treated them.

Unspoken Knowing – I See You

Clients come with many intersecting identities. As counselors, we may connect with one or a few identities and build an initial framework for understanding (Ratts et al., 2016). The COCs in this study reported that feeling connected was most substantial with clients of color. For example, Amelia shared their experience and how oppression connects them to their clients.

> I believe there's a different connection when working with a client who may share similar identities. Sharing similarities in a sense of— we are both people living in systems that oppress us, any power differential can be softened with these similarities ... I don't think there is a word. It is when they walk in the room, [deep sigh] like that is the best way to describe it. They think, 'I wasn't expecting you,' and it's relieving to have a dialogue

> about identity, culture, and the beauty of visual representation. As the masks get removed, you don't have to hide because even with different identities and stories, we both understand what oppression feels like and how that impacts our mental health.

This response acknowledges the reality of oppression and that there can be a more robust connection for healing together through oppression. Amelia's ED experience and multiracial identity tie them to clients with EDs, with even deeper intentionality with POC who have EDs.

Brianne agreed with Amelia when asked about working with clients of color. She said, "It was sort of an unspoken knowing. And I've had clients share with me how helpful it was for them not having to explain or keep explaining what was going on for them." This connection is not unique to eating disorder work but is a thread in the intentionality of the COCs in this study when they work with ED clients. Esmeralda, who is Latine, mentioned that in the space of therapy, even the country they are from is no longer a disconnect. Esmeralda shared:

> There's that little bit of a connection, even if we're from the same country or not. Like there's just that commonality of certain experiences, even if we have different identities. There's just such a powerful connection in that… that acknowledgement of each other of like— we both exist in this space together. I see you and you see me.

Participants described a connection and meaning through race and ethnicity. This comment from Esmeralda holds a more profound meaning when considering the expanse of Latin countries. Such countries have numerous languages and ethnic cultures unique to cities, regions, and states. It would show cultural incompetence to assume any Hispanic or Latine client would connect with Esmeralda just because she is Latine. However, her statement also invites the conversation of how oppression and marginalization within the United States may erase barriers between Latine people from different countries. Connecting with clients from different countries shapes

her intentionality in new ways, strengthening her understanding of ED work and her place in the profession.

Cultural Humility

As I listened to participants' responses, my mind returned to how we find meaning in a phenomenon. As tentative manifestations moved toward contexts, it became evident that intentionality was unstable and always moving. Considering the connecting thread COCs have through marginalization, one might assume an inherent level of cultural competence. However, participants also acknowledged their differences and described an openness to learning about their clients' cultural aspects, known as cultural humility. Cultural humility is the openness and willingness to learn about individual cultural experiences, whereas cultural competence emphasizes cultural knowledge (Zhu et al., 2021). Jade provided an example of how this connection can shift and change.

> When we have shared identities with clients, I think that, in many ways, it can be a really solid connector. I've also learned that I can't depend on that. Just because I am a Black woman, if another Black woman comes into my office, that doesn't automatically mean that she's going to feel safe in my care.

Tanesha also shared, "just because I'm Black doesn't mean that I understand like everybody's experience." Going further, Dee stated,

> It has felt easy for them [clients] to build a relationship with me … And at the same time, I try to check my assumptions. Just because the client is a minority, maybe they grew up in the same exact way that I did and did the same exact things, and their family dynamics are similar and ethnic in terms of their ethnic makeup. But I shouldn't assume that what I'm thinking is exactly what they have experienced.

And even within that humility is owning privileges, as Esmeralda shared:

> One of the things that I talk very often [about] with my clients is the fact that even though ethnicity-wise, I'm Latina, I am like a white-skinned Latina or light-skinned Latina. And that means that my experiences are incredibly different from those of a Black Latina.

Constructional illuminations appeared after processing the words of the participants. These findings offer a deeper understanding of why some clients want a COC. While working in the ED field, the unspoken knowledge that occurs with these COCs ebbs and flows as clients present with different racial and ethnic identities, marginalized statuses, and even within cultural groups. I realize POC preferring to be racially matched is not about my ability to be culturally competent; the unspoken knowing offers a safer place for clients to start their recovery journey. A COC offers a healing balm when clients struggle with a life-threatening, often shameful, and guilt-associated disorder. This balm offers relief through understanding oppressive systems and bringing healing from their ED within the framework of their culture.

Sense of Duty- I Got You

As I reflect on my journey through the ED world, there has never been a moment where I felt I had to keep working with the ED population because if I did not, no one else would. I was drawn to helping clients because I knew how to treat EDs and loved being part of their recovery journey. So, when some participants in this study shared a sense of duty to their communities to remain in the ED field, this knowledge veered from my assumptions. Tanesha shared:

> Specifically with the Black population. Because I feel like it is so underrepresented and so many people are affected by it, but they don't know that that's what it is. So, in a way I kind of feel like a sense of duty. Like now that I have this information, I want to make sure that I can share it within my community, so people can get the help that they need.

Tanesha described a sense of duty to her community that connects her meaningfully to ED work, as her role is shaped by something greater than herself. She explained becoming clients' connection to the ED world and reshaping the phenomenon into a more inclusive space for Black people.

Tanesha was not the only participant who referenced a sense of duty or feeling of a commitment to their community. NK97 recognized that she had to represent South Asians when she said:

> As a South Asian, there's not a lot of therapists who are South Asian, and I realized when I became a therapist that I had to cover all the areas we don't talk about in our culture. Eating disorders were definitely one of the big ones because food is such a huge thing in our community, but so are body shaming and judgment and things around that. So, I was like this has to be something I continue.

Becoming aware of all the mental health issues that can impact their community creates a sense of duty to continue working on advocating for their needs. However, it does not mean that COCs are obligated to take less compensation for their skills. Esmeralda expounded on this when she shared that a dietician expected her to accept Medicaid because she spoke Spanish and worked with EDs.

> I was the only person in that room when they expected I was going to be the person that accepted Medicaid, while everybody else was private pay … but it was just that expectation that I'm the one Latina person in this room, I'm the one that has to take Medicaid and never mind my own concerns related to income and all of that.

This provocation ignited an honest self-reflection recorded in the post-reflexion below.

Post-Reflexion Entry, November 30, 2022

When she spoke about being asked to take Medicaid it hit home that we may assume that it is her responsibility to help people from her community despite her need to make a living- do we do the same thing for our communities? For a moment, I thought, "but don't you want to help them?" Of course she does! But does that mean she has to earn less? Doesn't this perpetuate lower earnings for POC, even for those who have professional degrees? She is allowed to be successful, in whatever way that looks like for her.

A sense of duty constructs one of the most intentional ways of being in this phenomenon. The meaning this gives to working in EDs extends deeper into how these COC are in relation to their clients, the ED work, and finding fuller purpose in their work.

Exhaustion-Carrying a Heavy Load

ED work requires mental toughness for all counselors (Graham et al., 2020). However, when Miranda said, "it does take a lot, mentally, for you as a counselor," she had the added layers of being a COC working in the ED field. Participants shared that being an ED COC is more than engaging in the everyday work of EDs; there is an intensified burden for COCs to advocate for clients, educate peers, and prove they belong here. There is cultural understanding, enduring microaggressions, and searching for research or treatments that best fit their clients of color. They reported that these additional layers strengthen and diminish their connection to the phenomenon. For example, as I inquired about how ED work is different for COCs, Ellie stated:

> When there are diversity factors, we would be looked at as like, "Well, what do you think?" And we would have to educate our peers. And that was incredibly frustrating because it's not our responsibility. We can do some of it, but we can't do all of it.

Participants described a pull to connect with cultural aspects of ED work but then a push away from others who would take from her. Ellie felt others expected her to do the work of educating

herself and then offering knowledge to them with no effort on their part. Esmeralda also recalled some of the pressure she put on herself to work harder than her White colleagues. She said:

> I was already putting so much pressure on myself, but then I felt like other people were putting that pressure on me as well. So very isolating ... Now it brings feelings of anger and frustration that I'm able to direct toward others. But in the past, I would direct those feelings toward myself, thinking that I had to be the person that did all that instead of them making more inclusive spaces. And then I came to realize, well, no wonder there's not more of us in the field … they just realize, you know what, this isn't, this space isn't for me.

Lastly, despite the exhaustion of the work, Amelia noted persevering and bringing awareness through conference presentations. This choice to present on their own accord reshaped Amelia's connection with the ED field. They passionately declared:

> We have to advocate for different things and different treatment for our clients and also represent our clinicians who have been historically oppressed … And I think eating disorders alone is just really heavy work. It can feel exhausting. It can feel tiring because change doesn't happen overnight or in one week. It takes a lot of work ... And getting the feedback that we did felt more validating and more affirming that we're supposed to be here, we exist, and we are doing this work for a reason.

Amelia's "really heavy work" reveals the challenge of working in EDs as a COC. These words shape the depth of Amelia's connection to the phenomenon as they work to exhaustion to bring anti-oppressive frameworks to ED treatment. This connection for Amelia initially created tension in my intentionality with ED work, and I had to bridle my judgment and preconceived ideas. When Amelia used the words "oppressive frameworks" related to ED treatment theories, I

hesitated to consider the theories I have treated hundreds of clients with as oppressive. Since Amelia experienced them as a child, I had to validate their perception of the treatment. However, I wondered if the framework or the person treating them was the oppressor. This dissonance is a new thread that I continue to ponder and acknowledge that my White privilege hinders my understanding of how these theoretical frameworks oppress marginalized clients. Moreover, I can actively pursue cultural competence to limit oppression or microaggressions with my clients.

When working in the ED field, the COCs in this study reported enduring an intensified burden that is almost inevitable, given the social and cultural contexts of the ED field and the existence of White invisibility. As an ED counselor, I experienced pressure to help my clients recover, but not the pressure of changing oppressive frameworks, proving I belonged in ED work, or teaching COCs how to work with White clients. Reflecting on these findings, it is valuable to acknowledge our differences but not to position our experiences as more or less difficult than others. The effort and exhaustion I have endured working with EDs come from the complexity of the disorders. Most clients need advocacy for treatment, as insurance companies are stubborn with approving HLOC and extended sessions. There is an effort on my part to be culturally competent and learn new skills and treatments. Where I move away from the experiences of COCs is in the added layers of experiencing microaggressions, educating White peers on cultural issues, and proving I belong in EDs. These are unnecessary social and systemic layers placed on the shoulders of COCs working with an already challenging disorder, causing exhaustion and continued oppression. As I produce this study, my relation to these COC and the goal to reduce exhaustive environments becomes an added way of being in the ED field.

Microaggressions- Are You Seriously Saying That to Me

Events in the world play a role in shaping and reshaping connections, as working in EDs is co-constructed with societal events. In a fear-stricken pandemic and a tumultuous political environment with increased violence and injustice towards POC, two counselors brought up experiences with racism related to the COVID-19 pandemic and increased murder of Black people by police, seen through police body cameras.

During the COVID-19 pandemic, Mary, who is Asian, received an email from a colleague who wrote, "We need to get you vaccinated." Though she noted that everyone at her workplace was encouraged to be vaccinated, she was the only one to receive emails about it. She shared:

> I was pretty much targeted, when there was just an influx of people suffering from COVID in my country. They just thought that I might have gone there or just being an Asian, you know, she has contracted [it]. It was just like a slap on my face, you know?
>
> So, I ended up leaving that job because … it was disrespect. I cannot just stay in that job.

Mary could not stay employed due to discrimination and experienced microaggressions that led to relocating in a tumultuous time of uncertainty and lack of employment options due to COVID.

Instead of a colleague, Brianne described experiencing a "microaggression bordering on discrimination" from her boss. After the Breonna Taylor verdict, when the police officers who killed an unarmed Black woman in her apartment were charged solely with civil rights violations, she asked not to be assigned new clients for a few days. Her boss said, "I do not pay you to bring your outside struggles into work." Brianne's experience created a sense of disbelief that a leader would say something so insensitive. When she shared the experience with me, I did not hide my facial expression of shock, which offered more room for Brianne to continue sharing

about that time frame. Sharing experiences of microaggressions and discrimination showed a level of trust and vulnerability. As some White individuals will minimize or invalidate a POC's experiences with racism (Brown et al., 2018), I appreciate these COCs' willingness to trust their stories with me.

In addition to race, another identity that COCs in this study reported as a source for microaggressions was socioeconomic status (SES). Miranda, a school counselor working at an affluent hospital on the weekends, found that wealthier patients treated her differently than those from lower SES. She shared, "when you're Black, working with people with high SES in that small community of the hospital, you see how people treat you differently, or they don't see you as competent." Despite her many years of education and a master's degree, Miranda described how being a Black woman negated her competency in the eyes of wealthy individuals. Discrimination from these clients created a distance from building trust or feeling safe working in the ED unit. However, she noted that her students respect her as a school counselor and other school counselors rely on her ED knowledge. She explained that the radical differences in these two work environments contribute to how she makes meaning of her work in the ED world.

Every COC in this study shared an example of microaggressions and how each act disrupted their connection to ED work. One final example demonstrates a microaggression related to colorism, which can change the threads connecting ED work when everyone seems to question them. As Presley Marie self-identifies as "White passing," she reported experiencing discrimination from White clients and clients of color. Presley Marie went on to tell me:

> People are always like, really, you're Hispanic? I would've never guessed … But for those folks that did ask, they were minority clients. And so I'd happily say, yes, I am Latina. Folks would ask, "but you're White, right? So, you don't know what it's like to

> be," and I would have to say, no, I'm actually Latina. Here's a little bit about my background. And then I could see these walls kind of shift a little bit.

Presley Marie's experience entangles two threads of intentionality: White passing with White clients and White presenting with POC. She noted that when working with White clients, she avoids instances of microaggressions because clients assume she is White. When working with POC, because she presents as White, clients may assume she cannot understand their struggles because she lives with the benefit of White privilege, despite being Latina.

The threads to this phenomenon become entangled as COCs endure microaggressions. Whether we consider the contextual variables of world events, SES, or the nuanced variable of race, the participants in this study constructed meaning through their experiences with microaggressions and discrimination. They shared how their experiences led them to change jobs, work in uncertain environments, or push to attain higher degrees. Other participants responded by challenging the status quo, seeking support from other COCs and families, or starting private practices. None of the participants interviewed disconnected from the ED field; however, several participants admitted they were close to leaving the ED specialty but found support and pushed through because they felt this was where they were needed.

With a White interviewer, discussing microaggressions could have been challenging to be completely open and honest with the participants. I appreciated how each participant shared their stories of oppressive environments, unkind words, actions of dismissal, and possibly uncensored comments about White spaces. I am not ignorant to believe they spoke to me as they would to another POC about these topics. However, after each interview, I felt a shift in the authenticity of our relationships and a stronger thread connecting the participants and me to ED work as I validated their experiences and expressed my desire for social change and justice.

Provocations

In PIP, provocations become central to exploring the phenomenon. Vagle (2018) saw provocations as catalysts that powerfully shape or ignite the phenomenon. These catalysts are similar to Deleuze and Guattari's philosophical idea of lines of flight. In these lines of flight, we work on the edges and margins and reconceptualize the intentional connections by entering into the middle of entangled contexts (Vagle, 2018). Provocations are not a consensus of experiences among the COCs; instead, they are generally individual lines of flight. My job is not to find the phenomenon's beginning or end or figure out what caused these participants to act in any particular way in their intentionality. Instead, it is to present the intentionality that connects meaning that runs through the treads of these COCs' relations with working in the ED field. Reading through the interview transcripts from this study, I looked for comments that took off and challenged my understanding of the world and the work. Six provocations emerged from the interviews.

Vulnerability

Some people become counselors to heal themselves (Conchar & Repper, 2014). But what happens when a counselor does not need healing but becomes harmed? For NK97, putting herself in a daily barrage of body hatred and eating rules from clients inevitably seeped into her mind and caused disordered eating and body image issues. NK97 explained how this occurred for her.

> One year into it I was feeling good, and then I started to gain awareness of my own eating patterns. I would say talking about it too much when you get into this, you will end up paying attention to yourself. And if a client's constantly telling you 'my thigh is fat over there, my thigh is big over there,' if they say it 30 times over three weeks there's going to

> be a chance you're going to notice your own thighs, right? Even if I didn't have any disordered eating patterns, I still had shame around overindulging in food and acknowledging that that shame comes from not just me but also how I grew up in society and things like that … So, I think like that was the hardest part about being an eating disorder therapist.

This provocation of vulnerability represents the phenomenon's through-ness as the counselors come to be in relation to the ED. Without a personal history of an ED, they may connect to the phenomenon from a position of a healer. However, as they engage longer with the ED world, their intentionality may shift from the healer to a state of vulnerability. As NK97 illuminated, ED counselors may struggle with their body image and eating concerns, given their exposure to clients' struggles. As humans who experience the pressures of society, adequate opportunities exist to fall into the negative influences of diet culture and social media. As NK97 noted, this temptation is one of the hardest parts of being an ED therapist; I recall my reaction to her experience in my post-reflexion.

Post-Reflexion Entry. November 15, 2023

In a way, I think I wanted someone to validate the struggle of listening to clients talk about their bodies and what they can't eat all day. When NK97 responded to my question about what it's like to be an ED counselor, I felt seen. As my boss never validated my concerns about taking on some of the traits of EDs, it was refreshing to hear I was not alone. Perhaps this is more pervasive than I thought.

Reflecting further, the therapeutic alliance is not one-sided. There is a level of reciprocity that impacts the counselor. For me, clients I was closer with or could see myself in then ignited thoughts about my eating habits and body. Constant conversations about what is healthy and how bodies should look with clients I admired and respected were often a vulnerability for me. This

vulnerability may not manifest for every ED counselor. Perhaps there needs to be an underlying dissatisfaction with self or insecurity of body acceptance for a client to influence a counselor. For me, the threads of intentionality with the ED work shaped and reshaped when working with these clients.

Race as an Asset

The COCs in this study described experiencing microaggressions that create distance between their desire to work in the ED field and their belief that they belong there. However, as NK97 and I discussed the benefits of racial similarities with her clients, she expounded on race as an asset. She mentioned:

> South Asian clients and their parents tend to trust me more. A psychologist in our team right now, who's been in this field for 25 years, tells me that sometimes she can't say something to a parent, especially like a South Asian parent. But if I said it, they would be willing to more listen because they see that the way I'm saying it makes more sense to them because I know how they're thinking or how they grew up and all of that stuff. But if she said it, they would not take it seriously**.** *There's no other context that I can see where a doctorate is not given as much importance* [emphasis added].

The context of race and educational degrees highlights how intentionality takes shape and moves through the living of the phenomenon. NK97 explained that she moves away from ED work when she faces racial discrimination. Then, in a new occurrence where her cultural identity was more significant than a doctorate, she became aware of her indispensable value to the ED field and her clients of color. The notion that race is both an asset and a liability in the ED world became part of the phenomenon that took off and fled from my understanding.

This provocation created a line of flight that took off from the assumption that people with prestigious professional occupations or educational degrees are more regarded. In this one moment, there is evidence that race is more powerful than education in building trust in some communities. After listening to NK97's transcript again, I quickly shared this finding with a dissertation committee member. For me, it reiterated the beauty of community, shared values, and the truth that people look for those who know and understand when they are afraid. There is a peace that those with similar experiences will keep us safe and offer answers that embrace shared beliefs.

Complexity

EDs are complex and multifaceted. Each client treated has additional issues or identities that make the work cognitively demanding. In my experience with clients, some contexts increased the work's difficulty. However, as Esmeralda spoke about working with Latine clients, she illuminated more layers of complexity. She shared how working with Latine clients differs from her work with White clients.

> When we have conversations of about race or ethnicity, that's going to look very different … like I can talk about culture with someone that's White from the United States, but when I'm doing some of this identity exploration with immigrant clients that hold many layers of identity it just becomes so much more complex … we're having a conversation about race, we're having a conversation about ethnicity, but then we add another layer of, are you an immigrant individual? But then we add a layer of, are you an undocumented immigrant? What does your support system look like? What are the policies that are in place that have an impact on your daily living and safety in this country? And how does that have an impact on your experience? And therefore, how

> does that have an impact on your relationship with food? But also, how does that have an impact on your relationship with your body when we have a conversation about skin color? So, it's just so many more different layers and nuances to the conversations as well.

Layer after layer of intersecting identities and social barriers that make treatment complex also reconstructs the intentionality with the phenomenon. She described finding herself in relation to the world of ED for Latine clients in more meaningful ways. She noted that her knowledge and understanding allowed for the nuances of working with POC and stabilized her place in the ED field.

Another complexity that emerged was the intersection of race and higher levels of care (HLOC). Miranda shared that a young client who needed an HLOC did not want to go anywhere else for treatment because she was excited to have a counselor who looked like her. The mother reiterated that her daughter was comfortable with her and did not want to change counselors. Mom said, "This is important for her to have a counselor who looks like her." Though Miranda had the skills to treat her, this client needed an HLOC. This provocation positioned Miranda between keeping her client or sending her to an HLOC. Miranda knew she might not have a COC in an HLOC as she recalled being the only Black staff member at the in-patient ED unit. Navigating clients who do not want to go to HLOC is typical in ED treatment. However, it was not within my awareness that the fear of not finding a COC in those HLOCs would be a factor in possibly rejecting treatment recommendations.

Double Bind

According to Ferguson and Dougherty (2022), double binds are constant oscillations between alternative ways of being where you feel "damned if you do and damned if you don't,"

creating a sense of inescapability (p.11). Double binds exist in an organizational context where the worker experiences contradictions from subjective communication within their work environment's social and relational context (Putnam et al., 2016). The double bind provocation also has a solid connection to CRT and the tenet of interest convergence (Delgado & Stefancic, 2007). Due to the needs of patients at this level of care (LOC), there must be structure and discipline in ED units at the inpatient level. Counselors must help patients comply with eating and taking their medication; EDs are life-threatening (NEDC, 2018). When speaking with Miranda about her experiences of being a biracial Black woman in those spaces, she shared:

> And my nurses who I adore, they were like, my moms, my work moms would literally just be so happy when I was there because it also got to the point where the limits weren't being set. There wasn't the structure, which we knew the structure was important. The routine was important, and I was really big on that. I was assertive in that space. But it also was hard because I felt like later I, as I thought about this, I'm like, you know, are\/hey seeing me as like the angry Black woman or like the stern Black woman? You know, because I'm the only one who would like set the limits. Nobody ever said that to me, but it was something that was always in the back of my mind.

This reoccurring experience for Miranda suggests exploiting her cultural dispositions and using a younger, less experienced unit member to set limits and take on the emotional labor associated with enforcing compliance. She described self-censorship to avoid others seeing her as perpetuating a stereotype that would make her job more difficult. The nurses celebrate her assertive personality while she remains uncertain of how others perceive her when there is pushback on her performance style. Due to racism and stereotypes, her relation to and way of being with those she worked with becomes unstable.

Credibility

When looking at lines of flight in PIP, information takes off and constructs and deconstructs the phenomenon (Vagle, 2018). We enter into the middle of the phenomenon, not knowing the beginning or how it will change. This reconstruction became apparent in the final provocation as some participants discussed their decision to enter a Ph.D. program for counselor education and supervision.

Nine of the eleven participants in this study shared that they were in counselor education and supervision doctoral programs at universities across the United States. This provocation ignited the phenomenon of working in the ED field. It restructured the meaning of their work from clinician to researcher, supervisor, and teacher. I contemplated if their ED work influenced their decision to enter a doctoral program and reshaped their connection to EDs. Beginning with the paths these participants took to enter the ED field and then moving on to their current positions in doctoral programs offers clarity of how post-intentional construction of the phenomenon occurs.

Participants who mentioned their Ph.D. program shared how ED work connected them to their decision to pursue a Ph.D. Ellie shared, “I was frustrated at the limitations and barriers in the access of care for marginalized populations.” At the same time, Esmeralda explored how becoming a supervisor and researcher would improve access to information for students working with the Latine and undocumented Latine population. Like Esmeralda, Brianne shared that “the lack of education on eating disorders that I experienced in my master’s program and how that affected my counseling experience when entering the ED community led me to want to pursue my doctorate.”

While working in the ED field, many of the COCs in this study noted a paucity of research for POC and EDs, inadequate training in graduate school, limited access to trained ED supervisors, and a need to create culturally appropriate treatments. These discoveries ignited a desire to embark on a journey into academia that could give them a seat at the table. They perceived that having a Ph.D. brings respect and expertise necessary to make impactful changes, and thus wanted to pursue the degree.

Though working with EDs had some barring on choosing to obtain a Ph.D., the ED work itself was not a trigger for their continuing desire to pursue a higher degree. These COCs chose a field that is an untrodden path for counselors of their racial and ethnic backgrounds. They are trailblazers. These individuals tend to possess a continuing impulse to learn and grow and set their professional and life goals. Their persistence in the ED field already shows their tenacity. Additionally, from a critical lens, these COCs are pushing back the systems that oppress and silence marginalized voices by entering the academic space where change can continue with their research and teaching of future counselors.

Productions

After six tentative manifestations and five provocations, we have arrived at the two productions I identified in this study: *cultural inclusion* and *why we strive*. Productions are more stable experiences throughout a phenomenon that offer a core element to how people make meaning and become-in-relation-with the phenomenon over time (Vagle, 2018). The first production unique to the experiences of the COCs in this study is the desire for cultural inclusion in the treatment and understanding of EDs. Participants modified treatments to complement culturally-based needs as they discovered what did not align with their clients' cultures. The second production constructing this phenomenon is participants working with their clients. Even

with the added connection of the unspoken knowing with POC, most participants felt their relationship with all clients gave them purpose and a desire to continue striving in ED work.

Cultural Inclusion- What About Us?

While listening to the study participants, the act of searching for culturally inclusive treatment flowed through each participant's interview. Most of the COCs shared that the burden of professional development was challenging when looking for culturally appropriate assessments and treatments. They looked for ways to help their clients, but only having access to training directed toward Western treatment ideas created a vacuum of relevant knowledge and a burden for self-learning.

For example, after sharing that she noticed a lack of research, I invited Presley Marie to tell me more about how a lack of research impacted her working with clients. She explained that it becomes an ethical issue of piecemeal treatments, saying:

> It's impacted me because I've had to just go through as much literature as possible to try to piece together ways to care for my clients. And that doesn't feel right. It doesn't feel ethical ... So that way other people behind me are not trying to cut and paste different treatments together.

As PIP considers the recursiveness of a phenomenon, Presley Marie reported attempting to change the status quo from only using evidenced-based treatments that do not always consider cultural factors to implementing techniques that align with different cultures or the needs of her clients. She began changing the phenomenon to become less unethical and more encompassing of the needs of all people.

Like Presley Marie, Tanesha reported understanding that culture is an integral part of life, and as such, treatment must adapt to clients' needs. The context of each client's life is unique

and should not be dismissed as cognitive distortions. She explained, “I feel like I have to adapt everything [laugh]. Like it’s just not like clear cut. How do you tell someone to challenge a thought when I know it’s a valid thought based off the environment that they’re in?”
This quote demonstrates how validating the client’s environment allows Tanesha to connect to her client and support their reality. Tanesha explained that she could not turn back on what she knows about Black culture to align with research-based approaches. These approaches were not created for people of color, so these COCs reported intentionally modifying treatment approaches that bridge the gap between POC and traditional ED approaches. As Tanesha considers culture in the treatment, it adds new dimensions to the phenomenon, including the needs of POC with EDs.

Relatedly, Amelia presented the issue of creating culturally appropriate treatment and its toll on their well-being. Ownership of the extra work they do in EDs shapes the phenomenon of ED work. They said:

> I challenge those systems in ways that make me feel uncomfortable. But clients are not in a position where they can advocate for different treatment. I’m not going to do a treatment model that is inappropriate or stigmatizes them even more or even hurts them because they may already have racial trauma. I have to go to trainings, I have to read my books, I have to read research articles. So, I’m always backing up my rationale of why I disagree with a certain approach. I have to because nobody else is going to believe me. I just feel like I constantly have to persevere and sometimes it’s emotionally exhausting. It’s extra unpaid labor on my end … I think it’s having to constantly do the work to see what, what is out there.

This quote illuminates how Amelia works on the edges of the phenomenon. They are shaking things up for those who have been complacent and stagnant in ED treatment and research for POC. With work done by Amelia and others, how we understand EDs can incorporate a more inclusive picture of the reality of all those struggling with this disorder.

Cultural Linguistics

Along with cultural inclusion come issues with the language of EDs. Language can affect the way people look at the world and their relation to concepts within society (Dilkina et al., 2007). Linguistic determinism is the understanding that language may determine our thought patterns and perceptions of the world (Sharifian, 2017). Relative to this discussion, cultural linguistics "explores the features of human languages that encode culturally constructed conceptualizations of human experience" (Sharifian, 2017, p. 84). When exploring EDs across cultural groups, linguistic differences in naming the disorder or behaviors related to the disorder appear due to experiences within those cultures. Some COCs found that traditional American English describing EDs could be a barrier for people. Esmeralda stated:

> What I noticed is that the language does not align. It's realizing that the words in Spanish are not accessible terminology. And because of that, a lot of times we have entire communities that have struggled with the relationship with food and some shape or form disordered eating in nature, disordered eating in many ways. But it's gone completely unnoticed because we don't have the language, we don't talk about it, and it is incredibly normalized.

Esmeralda described how being a Latine counselor connects her to these clients with respect for their shared culture and reshapes the importance of her work in EDs. The language she referred to is not only about translating Spanish to English but also the inaccessibility of naming the

behaviors related to the eating disorder due to cultural differences in their experiences. Within the cultural linguistics of her community, westernized clinical terms may not represent the experiences people endure with eating and body image.

Within cultural linguistics, it is critical to know that cultural cognition is not uniformly shared by people within a speech community, as there are variations and differences in their access to cultural linguistics (Sharifian, 2017). Tanesha offered an insightful look into how cultural linguistics appears among English speakers in different cultural communities.

> I had to explore more … Like do you make yourself throw up instead of purging or what do you call it? It's like with restricting for example, it would be like 'yeah I just don't eat like' <affirmative>. So, what does that mean? You just don't eat? Like are you skipping meals? Like you don't eat one meal a day, two meals a day? It's not seen as like restricting. It's just like, 'I ain't hungry, so ain't gonna eat' kind of thing. The other thing I often see like with Black clients is like, 'yeah when I get like sad and stuff I be eating like a whole lot.' So it's like, well tell me more about like what that looks like. It's not necessarily like I'm binging, well it's described more as like emotional eating when it's really more like a binge, you know, that's driven by their emotions. So, putting language to it in that way to describe like, this is what you're actually doing when you say these things.

Tanesha described finding the cultural linguistics that helps her clients explain their behaviors and then connected those to how EDs look historically. She became the bridge her clients of color need to recognize what is occurring in their lives through their cultural lens. As COCs experience working with POC or clients who understand or identify the disorder differently, the phenomenon changes, and meanings take on new shapes.

Combining culture and language, Jade shared an experience elucidating the connection between ED work, culturally appropriate treatment, and language. When working with a highly ill young Black child, she realized his ED pathology was outside their understanding.

> The family dynamics and some of the multicultural pieces that in consultation team meetings people just didn't understand. I don't know that I had all of the language to really explain what was happening and really ask the right questions to get the right support and the right help. But again, there were parts of this patient and family's experience that I understood on a cultural level that I couldn't articulate to anyone else in the room. And so that made things difficult for me to feel supported and me to feel like I was adequately supporting this family.

When I recall Jade telling this story, I could discern her worry that she had not done everything possible for this family and her disappointment that there was no multicultural training sufficient for her colleagues to understand her client. In this instance, her connections to the phenomena were making and remaking themselves as she had cultural understanding and ED knowledge, but then unmaking as she could not connect the two contexts.

Culturally inclusive treatment and adequate language are critical to moving ED work into a more socially just world (Igou et al., 2021). ED counselors need flexibility in classifying behaviors so all people with eating disorders, disordered eating, or eating concerns can receive the treatment they deserve. The COCs in this study described how they sought, developed, and shared culturally appropriate treatment, which creates intentionality with this phenomenon. These intentional relations manifested in acknowledging cultural linguistics, searching for culturally inclusive treatment, and acknowledging that EDs can affect everyone.

Why We Strive

Throughout my interviews with participants, I witnessed the ebbs and flows of connection to the ED work through their changes in demeanor, voice, and facial expressions. Dependent upon the question asked, participants demonstrated a construction and deconstruction of their relation to the ED work. However, when discussing why they strive so hard in the ED field or their positive experience in ED work, every participant expressed a deep connection to their clients. Regardless of racial similarities, these COC make meaning in their relation to the people they help. Brianne, Ellie, and Esmeralda each shared their feelings about clients.

> **Brianne:** I think that as, as hard as it is to be a person of color in this space, there are these moments and experiences I've had with clients that make me happy to be in this field. Whether it is fighting for a client to continuing treatment because their insurance is crap and them hugging you because no one's ever fought for them that hard. Or my favorite thing is when clients are like, Brianne, I couldn't wait to tell you this because I knew you'd be so proud of me … and I wish that that these other things didn't have to merk it, or like make it so much harder to be in this field because it is a great field.
>
> **Ellie**: I think it's a great privilege and responsibility. Honestly. I love my work with my clients. I mean there's been countless client interactions that have meant the world to me. And I think that a lot of the time what I try to do is empower my clients that they have a voice and that they know that they deserve to be seen and heard no matter what.
>
> **Esmeralda**: I love the work. This particular population, they experience so much shame and guilt. They experience so much isolation within what they're experiencing that it can be such a beautiful space to share with them. Clients are beautiful, just beautiful, beautiful souls that I think a lot of times people don't get it, don't understand. And I'm

> always eager to see the times in which they come back and say about this tiny little experience that might, may be tiny for other people, but for them was such an amazing experience and like, what such a win. I wouldn't trade that for anything else.

Each participant shared beautiful thoughts about their work with clients. As they spoke, I connected to them through our shared love of the clients. When Esmeralda said, "clients are beautiful souls," there was a depth that reached into the struggle of a life-threatening disorder, the resilience of the client and their family, and then the compassion and hard work required on a counselor's part. These counselors do not see clients only as their illness but as who they were before the ED took over and what they can become again. As we enter into the middle of the phenomenon, where and how these COCs enter their clients 'lives can shape their intentionality.

Summary

I used PIP to explore the material gathered through study interviews and found a space to listen to participants' experiences without looking to create themes or define an essence. Instead, I discovered tentative manifestations, such as feeling unprepared for the work, seeking a sense of belonging in the isolating spaces of the ED field, and a deeper connection to POC through an unspoken knowing. Feeling exhaustion due to being the only COC and pressure to know everything about working with POC who have EDs also manifested. Along with those tentative manifestations, I found provocations that catalyzed the phenomenon. The vulnerability of ED work, the asset of race compared to a Ph.D., and the double-bind between authenticity and expectation of others all took off as lines of flight. Lastly, I suggested productions of cultural inclusion in treatment with an additional issue of cultural linguistics, and the joy of working with the client is why they continue to strive despite exhaustion and the difficulties of ED work.

As mentioned at the beginning of this chapter, you are now part of this phenomenon, and how you let this information shape you becomes the first step to social and systemic change. As I worked with study participants and delved into their stories, my connections to ED work strengthened in purpose and direction. We cannot dismiss what we have learned about the difficulty of working with EDs, the loneliness of being one of only a few COCs, or the feelings of fear when working with a life-threatening disorder with limited training and supervision. How do the discoveries of this study change how we will move forward with ED work? As counselor educators, I hope these COC's experiences will spark something in each of us to bring awareness and do our part in educating and supporting our students who work with EDs.

Post-Reflexion Journal Entry 2/3/2023

It feels unfair that I have grown so much from these interviews, and I can give little back to these wonderful people. What is a gift card compared to the knowledge, growth, and cultural humility I have gained through learning about their lives in the ED field. When I think about many of them sharing their sense of duty to the community or being the voice for their clients of color, I start to see that I can play a role in carrying their gift of knowledge to others. While doing this research, I have taught my students and ED trainees valuable knowledge that I gained from these COC. I was able to broach a conversation in class about Latine students feeling marginalized within marginalized communities, which gave two Latine students the opportunity to expound on those same feelings and begin a difficult dialogue with other marginalized students. In my ED training last week and with an ED lecture this week, I was able to give real examples of the barriers POC face in ED treatment and diagnosis as well as microaggressions faced by the COC working with EDs. Every conversation, lecture, or encounter I have about EDs has become richer with inclusion and awareness of the diverse needs of ED clients, and each student I teach with my new understanding and knowledge is another person who can bring about change for POC and COC, regardless of their race or ethnicity.

Chapter 5: Discussion, Implications, Limitations, and Future Research

"When we identify where our privilege intersects with somebody else's oppression, we'll find our opportunities to make real change."

— Ijeoma Oluo

In this study, I aimed to bring awareness to the experiences of counselors of color (COCs) in the eating disorder (ED) field and create a dialogue about systemic and social change related to their experiences. Using Post-Intentional Phenomenology (PIP) as the methodology, critical race theory (CRT), and systems theory framework (STF) as theoretical frameworks, I analyzed material through a whole-part-whole method that brought out tentative manifestations, provocations, and productions. The primary research question was: what are the lived experiences of COCs choosing and working in the ED field?

After developing the initial findings, I used CRT and STF to identify parts of the phenomenon through these frameworks. From the interview material, I posited six tentative manifestations; *unprepared, isolating spaces, unspoken knowing*, *exhaustion*, *sense of duty*, and *microaggressions*; five provocations; *vulnerability, race as an asset, complexity, double bind,* and *credibility*, and two productions; *cultural inclusion* and *why we strive*. In this final chapter, I discuss these findings in relation to previous literature. I also consider the implications of these findings and how they add knowledge to the field of counseling. Lastly, I acknowledge the study's limitations and suggest future research considerations.

Discussion

Choosing ED Work

The first part of the research question I used in this study explored the experience of COCs choosing the ED field. By considering how these COCs chose to enter the ED field, I gained initial information that may help counselor educators increase counselors in training

(CITs) of color in ED work. The COCs in this study were guided by content and process influences within their life systems to work with EDs. When choosing a career path, STF suggests that content influences, such as personality, family, society, and environment (e.g., historical oppression, socioeconomic variables, workplace structure), directly impact career development. Opportunities for the career must also present themselves (Arthur & McMahon, 2005).

In a 2012 study about content factors impacting career choices, Barnes et al. reported previous work experience and knowledge of the specialty as influences on specialization in counseling. Other researchers have identified additional factors, such as personal experiences (Graves & Wright, 2007), service to others (Tamayose et al., 2004), and interest in the specialization (Foster et al., 2009), that influence students in choosing counseling specialties. The COCs in this study also align with these factors. They reported previous work experience, a desire to serve others, interests in the specialty, and personal experience with EDs as influences on their choice to work in EDs.

Unlike previous research (Foster et al., 2009; Graves & Wright, 2007; Tamayose et al., 2004), fortuitous opportunities were common for these participants in specializing with EDs. Creating opportunities offers counselor educators a direct path to increasing representation. They can encourage CITs of color to explore internship placement in EDs or arrange for placements in EDs to be available for CITs to choose. When teaching about EDs in various courses, counselor educators can reiterate the importance of understanding EDs and alleviate fears of working with this population. Local chapters of Chi Sigma Iota can offer free or low-cost workshops on ED training to increase interest for students. Lastly, college counseling centers may be encouraged to bring counseling students to run ED groups.

Along with opportunity, personal experience with an ED was a common influence in choosing this work. The process influences such as past experiences and the recursive interaction between the ED world and a person with an ED can explain the high rate of EDs within a group of ED counselors (Arthur & McMahon, 2005). Some participants spoke at length about their EDs and endeavored to establish their connection to choosing this line of work. COCs in this study mirror research showing rates of EDs ranging between 24% and 47.5% for ED counselors (Bachner-Melman et al., 2021; De Vos et al., 2016). More than fifty percent of participants (55%) in this study chose to work in EDs due to a personal experience or a family member with the disorder.

In previous research, counselors with lifetime EDs felt they offered more insight, a stronger therapeutic alliance, and greater awareness of subtle behaviors associated with the disorder (Bachner-Melman et al., 2021; De Vos et al., 2016; Warren et al., 2013). Participants in this study also reported that they would understand their clients on a deeper level, empathize with their struggles, and help them recognize the function of the ED more quickly due to their personal experiences. For example, after sharing her ED story, Mary noted that she believed her experiences helped increase her empathy and understanding of clients' struggles with ED. She could also share her recovery journey with clients to engender hope for their recovery.

ED experience is not always beneficial, as De Vos et al. (2016) reported that counselors with a history of ED experienced enmeshment and over-identification with clients. Likewise, not every COC in this study reported their ED as beneficial to counseling. For example, Presley Marie explained that she could understand an ED but initially avoided it due to fears of countertransference and over-identification. Regardless of the initial desire to work with EDs or

avoid them, having personal experience with an ED, to some extent, influenced their journey into the field.

For these counselors with an ED history, the intrapersonal factor of race also informed their choices to work in EDs. Like the wounded healer that Conchar and Repper (2014) describe as a person who chooses to be a counselor due to their own wounds, some of the COCs in this study described experiencing oppressive environments and difficulty seeking treatment as POCs, which led to their choosing ED work. Through their struggles to find competent counselors and treatment, these COCs reported rigorously pursuing ways to help POC access care and offer culturally appropriate treatment. Fighting for insurance, searching for resources, and finding the correct language emerged as behaviors related to their understanding of struggling with EDs. Being connected to their clients in different ways strengthened their understanding of the EDs, dedication, and desire to choose ED work.

Beyond participants' motivations to work in EDs, I also sought to explore participants' experiences working in the ED field. In the following section, I explore the tentative manifestations I identified in chapter four and compare them to previous research. Some manifestations are discussed through the CRT framework, while others are related to previously reviewed research and new research studies.

Tentative Manifestations

Tentative Manifestations are connections across participant experiences with the phenomenon (Vagle, 2018). They are not themes; instead, they materialize and shift throughout the encounters of the COC participants with ED work. Each manifestation is a thread that connects the participants to the phenomenon and shapes it (Vagle, 2018). The six manifestations

I identified in this study connect to previous research discussed in chapter two and expand the foundation of knowledge pertaining to working in the ED field.

Unprepared

The COCs in this study reported a pervasive belief of unpreparedness to tackle the complexity of EDs. Feeling unprepared can lead to lower self-efficacy (Mullen et al., 2015), and for these participants, it also led to fear, frustration, and concern for the ethical treatment of the clients. Participants shared similar feelings to those in Labarta et al.'s (2023) study, where researchers found that the most significant challenges in ED treatment were a lack of graduate-level education and specialized training. Participants in Reid et al.'s (2010) study also reported that despite some training focused on EDs, they did not feel they had the specialist knowledge required to effectively counsel the ED population. The COCs in this study consistently declared that ED training was nonexistent in graduate school and that seeking training once in the ED field was their responsibility. This finding aligned with previous research and illuminated a concerning need to prepare ED counselors.

Though new counselors can work with most presenting issues and populations, when working with EDs, ethical codes require training beyond introductory graduate counseling courses (Williams & Haverkamp, 2010). From participants' perspectives, the learning curve is high with EDs at higher levels of care (HLOC), and without adequate training, there is the potential to do more harm than good. Some participants shared that it was years before they had cognitive behavioral therapy (CBT) or other formal training that was not on-the-job learning. Considering that evidenced-based treatment (EBTs), such as CBT, show high recovery rates with EDs (Waller et al., 2012), treating clients without knowing these theories could be considered unethical or dangerous. On-the-job training is acceptable to begin working, but formal

workshops, conference sessions, ED literature, and supervision should be standard for all counselors within their first year working with this population. Like many counselors, the COCs in this study want to know the best treatments for their clients. Professionals further along in their careers must proactively guide new counselors in accessing training for clients' safety and their own self-efficacy.

Isolating Spaces

Finding a sense of belonging and feeling isolated working in EDs was reported as difficult for the COCs in this study. They shared that being ignored by other clinicians or needing to prove their capability led to self-doubt about their decisions to be in this field. Participants cited that the main barrier to belonging in the work was the homogeneity of the field. This barrier was also found in Jennings-Mathis et al.'s (2020) study about workforce diversity in EDs. For these COCs, White spaces created feelings of isolation and loneliness that led to wondering if there was a place for them in these spaces or how they might make a place for themselves at the table.

Like Jennings-Mathis et al. (2020), participants in this study noted the high cost of training as a challenge. This high cost presents as a means of gatekeeping toward new counselors. Access to certifications, which bestow expertise and prestige, is costly. Additionally, professional conferences specific to EDs often require travel, hotel, and registration fees in expensive cities. Some COCs noted that they were unsure if such conferences were worth the cost to attend when most sessions would not address multicultural issues in EDs or the cultural adaption of EBTs. Similar to the recursiveness of PIP, when participants do not attend ED conferences, they further lose an opportunity to connect with other ED professionals, potentially

including other COCs. When they did attend, they reported loneliness, isolation, and a sense of not belonging due to few COCs and limited discussions on the needs of POC.

Unspoken Knowing

Research on racial matching shows favorable outcomes for African Americans, Asian Americans, and Latin Americans (Meyer & Zane, 2013; Reyes-Rodriguez et al., 2014; Steinfeldt et al., 2020). The participants in this study all shared that being COCs was a welcome connection for their clients who were POC. The unspoken knowing of what it is to live in an oppressive environment, mutual understanding of experiences without explanation, or finding a safe space where the "masks can come off" aligns with research supporting racial matching (Cofield, 2022; Kim and Kang, 2018; Meyer & Zane, 2013). This tentative manifestation evoked deep feelings from the COCs as they spoke about this connection. Some participants mentioned that they connected quickly with clients of color, even if they were from different countries or cultures. Other participants described the powerful experience of meeting a client of color and seeing the anxiety dissipate from their faces as they realized they had a COC. Even with such connections, these participants noted recognition for differing levels of identity development and worldviews, leading them to maintain cultural humility.

Participants described having strong therapeutic relationships with clients of color and lamented their limited opportunities to counsel more POC. Many participants reported only counseling a handful of POC over multiple years, despite a desire to work with this population. Some participants noted that ED treatment is incredibly privileged and expensive and that unyielding insurance companies were the most significant barrier to treatment for POC. Even with increasing COCs in the ED field, these unresolved issues may continue to limit access to treatment.

Exhaustion

Previous researchers have identified that exhaustion among ED counselors can stem from treatment resistance, lack of reimbursement, and extra hours working (Warren et al., 2013), along with feeling drained, demoralized, and frequently on edge (Graham et al., 2020). Given that these studies were conducted with White counselors, the current study with COCs supports previous findings and adds other layers to the exhaustiveness of working in EDs. In addition to the reason for exhaustion that Warren et al. (2013) and Graham et al. (2020) found, the COCs in this study also reported carrying a burden to advocate for their clients of color, educate their peers on cultural issues, prove they belong there, endure microaggressions, and frequently search for research or treatments that best fit their clients of color. They explained that these added layers become a burden that can feel exhausting and create a sense of loneliness or fear that they cannot quit for fear that no one else will do the work.

The COCs in this study expressed that they feel tasked with teaching their colleagues about racial and cultural issues in counseling EDs. Though they want others to be culturally competent, they noted other ways to become informed over tasking COCs with multicultural education for EDs. For example, some participants explained that they present at conferences to educate other counselors. This endeavor can benefit their careers, bringing the fulfillment and acceptance that can come with session participants applauding and honoring their labor.

Microaggressions

Discrimination continues to exist, even in the counseling profession (Thacker and Minton, 2021). Sometimes, discrimination is enacted as a racial microaggression. Racial microaggressions are identified as subtle, pervasive displays of racial bias and discrimination (Houshmand et al., 2017). Each participant in this study shared instances of racial

microaggressions. These experiences disrupted the intentionality of their being in the world of EDs.

In a study of CITs' experiences with microaggressions in graduate school, Thacker and Minton (2021) identified two main categories: overt microaggressions and isolating consequences. The participants in this study also reported experiences with stereotyping, tokenism, erasure, and intersecting marginalization. They described isolating consequences such as underrepresentation, disconnection, discouragement, and feeling unseen and inconsequential. Though none of these counselors have left the field of EDs, many reported other COCs in the profession leaving hospitals, agencies, and graduate programs due to discrimination and microaggressions.

CRT posits that racism is an everyday occurrence for most POC (Ladson-Billings, 1998). Although extreme racism and discrimination, like that seen during the Jim Crow era, have lessened since then, POC face systemic racism and unfair treatment daily (Bleich et al., 2019). Whether in the workplace or society, these acts of racism can have a cumulative effect on POC and their sense of belonging and mental health (Anderson, 2013). Some participants in this study said they would caution CITs of color about working in the ED field. Many participants in this study said they would encourage CITs of color to consider EDs but proceed cautiously due to continued microaggressions and possibly oppressive environments.

Provocations

In PIP, we ask, what does not seem to fit? (Vagle, 2018). Provocations do not seek to align with previous literature as these moments take off and veer from assumptions. Looking at the provocations I identified in this study can offer insights into concepts that may have limited research but are essential to consider.

Vulnerability

Starting with the provocation of *vulnerability,* it is evident that EDs can influence clinicians' eating habits and body image. This finding is not a new discovery (Shisslak, 1989), but it was unexpected, with some older research supporting its existence. In 1999, DeLucia-Waack created a supervision model addressing the countertransference and overidentification of female ED counselors working in EDs. They noted that due to the sociocultural influences of society, counselors might become triggered by their clients who express similar beliefs about body and diet behaviors. For example, NK97 did not have a previous ED. Nevertheless, she still reported that by living in the same society, clients' ED stories served as a persuasive voice, causing her to engage in disordered eating and body shame.

Unlike other mental health disorders that are predominantly psychiatric, EDs can be culturally induced, partly by economic and social influences (Hesse-Beber et al., 2006). Though EDs are not disorders one chooses to have, working with EDs influenced NK97 to focus critically on her body and diet (DeLucia-Waack, 1999). This influence is not limited to the counselor's personal choices. Dee mentioned becoming more aware of the eating habits of her children and friends and making changes in her family's diets. Whether changes are healthy or maladaptive, counselors must seek supervision and examine personal beliefs or preferences (e.g., I would look better if I lost 10 lbs.) that can impact their ability to counsel effectively (DeLucia-Waack, 1999). Acknowledging the potential for countertransference with clients or developing disordered eating is an ethical consideration for counselor educators and supervisors to share with their supervisees.

Sense of Duty and Race as An Asset

The tentative manifestation of a *sense of duty* and the provocation of *race as an asset* connected cultural aspects of the COCs in this study. All of the participants came from collectivistic cultures, so their sense of duty to their community may stem from cultural beliefs. In these cultures, putting the community's needs over the self are valued and builds their sense of connection to the community. Due to their cultural similarity, we can see this value recognized by the parents of a teen who preferred NK97 over a psychologist with a doctoral degree. A reciprocal benefit comes with serving the community and being trusted by their community, which validates their choice to work in the ED field.

Even with a sense of connection to the cultural community, Dee and Presley Marie shared that their families did not support their work in counseling, especially not in EDs. Both reported that their families considered mental health and eating or diet behaviors typical life concerns. Though both ED counselors also felt drawn to support their communities, they recognized that perhaps people, including their families, are not entirely open to counseling and EDs. They shared that this is frustrating for them since they know how to support their communities but find that few POC with EDs come to them for counseling.

Complexity

The final provocation of *complexity* illuminates how layers of the client's identity can complicate an already complex disorder. Counselors must look for factors that influence the ED and what barriers exists to treatment (Hamilton et al., 2022). Though many people with EDs may have multiple layers of issues that impact their disorder, the COCs in this study expressed that POC and people with other intersecting identities require even more cultural awareness and adaptation. These COCs noted that they might recognize the contextual layers of clients from

their cultural backgrounds more quickly than White counselors. Understanding these issues, in addition to a client's ED, is critical for treatment and future recovery. In recognizing the multifaceted world of EDs, these COCs in this study bring attention to the need to understand the complexity of the work and why training and supervision are critical.

Another complexity in ED work participants noted is underrepresentation in higher levels of care (HLOC). ED clients may hesitate to enter HLOC, whether due to fear of leaving home, losing their independence, being forced to eat, or fear of recovery. In this study, Miranda's client initially resisted moving to an HLOC due to a lack of access to a COC at that level. Though hospitals often have POC on staff, most participants in this study shared that they were either the only COC or only one of two that worked on the ED units. Miranda's client's fear has merit and underscores the need for more COCs in EDs. Despite White counselors' capability to treat POC, some clients prefer a COC and deserve that option.

Double Bind

Double binds exist in an organizational context where the worker experiences contradictions from subjective communication within their work environment's social and relational context (Putnam et al., 2016). The *double bind* provocation also has a solid connection to CRT and the tenet of interest convergence (Delgado & Stefancic, 2007). Interest convergence proffers that White peoples only support social justice that benefits marginalized people when they benefit as well (Ladson-Billings, 1998). In this study, the tenet emerged when Miranda described a double-bind situation in which her natural personality aligned well with the needs of a highly structured work environment. However, she felt it perpetuated the historical personality type of "the angry Black woman." She noted that the nursing staff at her job encouraged and praised her work style as it made their jobs easier. However, when parents or patients were upset

with her strict adherence to rules, they expected her to defend herself. Thus, she described being caught between an effective working style and avoiding perpetuating a stereotype.

Credibility

Building *credibility* through earning a Ph.D. in counselor education and supervision was another provocation that took off. Nine of the 11 COCs in this study were pursuing their Ph.D. in counselor education and supervision to affect change. Participants explained that they were pursuing the additional degree to have a more substantial impact on moving the ED field into treatment that is accessible and equitable for all people. They further expressed their belief that earning a Ph.D. provided a place to conduct more relevant research for POC in EDs. It also allowed them to supervise new counselors, bring ED education into the graduate-level classroom, and work towards creating treatments that better align with the cultural needs of intersectional identities.

A Certified Eating Disorder Specialist (CEDS) certification also builds credibility and is the only certification available for ED counselors (Dennis et al.,2014). At the time of the study, two participants were actively working on their certification and expressed a belief that the CEDS is a highly regarded certification. Two other participants mentioned beginning the CEDS certification but noted that it was expensive and perceived that the credential had no financial benefit. Despite the desire to obtain this extra training and certification, the high cost and lack of financial compensation left some COCs in this study unsure about embarking on this certification. Nonetheless, being seen as competent, educated, and respected emerged as core features of some participants' decision to work towards their Ph.D. or the CEDS certification.

Productions

Cultural Inclusion

In addition to the provocations I explored, I identified two productions that continually create threads of connection and reshape meaning with the phenomenon (Vagle, 2018) of working in the ED field as a COC. The first production, *cultural inclusion*, embodied every participant's behavior, thoughts, and feelings in utilizing and modifying EBTs. When the COCs in this study worked with POC, they described a realization that EBTs are not always congruent with cultural healing. Study participants noted that they felt compelled to work outside oppressive systems and treatment methods that might harm their clients of color. Meyer and Zane (2013) validated this desire with their research. They found that when counseling clients felt cultural elements were essential to their counseling but did not perceive them as present, they were dissatisfied with parts of treatment. This dissatisfaction was pronouncedly higher with clients of color compared to White clients.

Relatedly, in a study on Native Americans with substance use issues, researchers found that by culturally adapting EBTs, counselors' treatments significantly improved clients' psychological distress and alcohol use (Kamilla et al., 2013). In alignment with this research, the COCs in this study reported modifying some of their treatments, delving into limited literature on POC and EDs, and piecing together EBTs to be more culturally responsive. They reported finding that this extra effort was valuable for their clients of color and was their responsibility to continue. However, most participants also reiterated that they do not speak for their entire community, and their worldview may differ from others that share their cultural background. Participants cannot carry the total weight of creating culturally appropriate treatments based on their own experiences as POC.

During the material analysis, as the production of cultural inclusion emerged, I realized this topic was an unexpected finding and had not emerged in previous literature. There was limited research on COCs in EDs, so I looked for research I believed this study would reflect. Sadly, it identifies how White invisibility impacted my ability to recognize this would be a core element of the experiences of COCs. I endeavor to become culturally competent. However, only utilizing multicultural competency without cultural adaption to EBTs is a disservice to clients. Though applying EBTs to POC engenders controversy due to underrepresentation in the research on most EBTs, scholars have posited that it would be unethical not to use them to some degree (Venner et al., 2013). Since EBTs are generally used for ED clients, it was outside my purview that others were struggling to adapt EBTs to meet their clients' cultural needs.

Why We Strive

In this study, participants shared their passion for helping their clients recover from EDs. Despite their passion, they reported similar levels of emotional exhaustion due to extra working hours as White counselors in EDs have reported in previous research (Warren et al., 2013). Moreover, the current study participants' exhaustion paralleled the findings of Graham et al. (2020), in which ED professionals characterized working with ED clients as draining, demoralizing, and frequently on edge (Graham et al., 2020). However, COCs in this study shared that despite the extra work, exhaustion, or feelings of isolation, they stay in the ED field for the clients.

Counselors acknowledged a more instantaneous connection with clients of color, but they all shared that working with any ED client gave them a sense of purpose, accomplishment, and fulfillment. Even with their White clients, they reiterated their love of the work and desire to become culturally competent counselors for clients of all races and ethnicities. Notably, some

COCs in this study mentioned wanting more POC with EDs as clients. Participants noted that working at an HLOC or in a less diversified geographical location led to fewer encounters with treating POC. Regardless of these contextual issues, most COCs in this study reported a passion for ED work and a recognition that barriers to treatment still exist for many people, and advocacy is needed to increase access.

Implications

Participants' experiences offer a solid foundation of knowledge about ED work for COCs and counselors in general. In addition to discussing the findings, it is beneficial to reflect on the implications of how this information may benefit counselors and counselor educators in their endeavor to support CITs of color considering ED work. Though numerous implications can emerge from the findings, six key implications are vital to consider and implement for creating systemic changes in ED education and work.

First, the participants' experiences in this study reflect the need for more support in graduate education. Most education on EDs is taught through a diagnosis and assessment course. When learning about the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or diagnosis, EDs are generally covered in a single lecture, as are most mental health disorders (CACREP, 2016b). However, with their complexity, the tendency to be secretive, and the high rate of death associated with them (Franklin, 2020), additional training on identification and treatment must be offered. Like substance abuse disorders courses or certificates, counseling students could be better equipped to recognize and treat EDs with an additional course focused on EDs. Integrating ED education into other counseling courses, such as theories, ethics, advanced techniques, or multicultural, would raise awareness of EDs and may increase CIT's willingness to engage in further training after graduation.

Second, with more education, counselor educators and supervisors ought to focus on competency in supervision. When CITs in practicum have a client with an ED, their supervision structure ought to become highly focused on the client and their treatment plan, goals, and progress. Counselor educators supervising such students should have some experience treating EDs or additional training on supervising CITs working with EDs. It is debatable if a practicum student should work with a client struggling with an ED; however, with appropriate supervision, practicum students can learn how to effectively treat their client and build self-efficacy toward working with this population.

Third, tasking COCs with finding ways to modify EBTs with culturally relevant treatment leads to exhaustion. ED research lags compared to other diagnoses with respect to cultural considerations. This lag is due, in part, to the inaccurate beliefs that EDs are a White woman's disorder (Halbeisen et al., 2022). As research on ED presentation in marginalized populations continues, parity with how to modify treatment would also benefit the counseling field. Proactive research into implementing all-inclusive diverse-oriented treatment techniques can offer a respite for these COCs and more quickly bring culturally appropriate treatment to clients. The inclusion of COC's perspectives on research would increase the breadth of racial diversity-related topics within the ED field. However, putting the responsibility of all non-White diversity research solely on COCs could lead to continued exhaustion and inappropriate, burdensome effort on their part. Collaboration among all ED professionals will enable all-inclusive diversity research that embraces the experiences of COCs and offers support in conducting the work.

Fourth, clients' preferences for racial matching and the consequential increased understanding between counselors and clients impact counseling. When discussing how

increased racial representation would impact ED counseling, the participants in this study overwhelmingly reported that it would lead to positive outcomes. Increasing racial diversity among ED counselors could lead to greater accessibility for clients, create innovative ways to challenge old treatment modalities, and open doors for clients looking for COCs.

Increasing COCs in EDs not only offers accessibility for POC but also brings access to all clients struggling with EDs. As there are often not enough counselors who specialize in EDs, an increase in counselors overall would positively reduce barriers to access. One way to increase COCs in EDs is for counselor educators to be more intentional in encouraging CITs of color to consider ED practicum and internship sites. Counselor educators may consider guest speakers who are ED COCs or create assignments focused on special populations such as EDs. They may want to encourage research for master's and doctoral level students focused on EDs and the many intersecting identities of people with EDs. Lastly, it would be beneficial to incorporate experiential activities such as social media searches, movie critiques, and other entertainment evaluations that impose unrealistic body and diet standards that can impact our clients of all ages and races to change the narrative around ED presentation.

Fifth, given that racial discrimination continues to perpetuate in graduate programs and the workforce (Thacker & Minton, 2021), counselors and counselor educators are called to work to eliminate racism, discrimination, and microaggressions. As CITs bring their worldviews into the classroom and the workplace, educators ought to challenge students' beliefs and behaviors that are antithetical to the counseling profession and break the ethical code of non-maleficence. In addition, by weaving multicultural discussions throughout all courses, students can continually self-reflect on their biases and behaviors. These discussions also allow educators to

accurately use gatekeeping when a CIT displays unprofessional behaviors or prejudiced beliefs (Glance et al., 2012).

Despite CACREP guidelines and the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016) that set the standards for counselor educators and counselors, acts of racism and discrimination alienate counseling students of color, making them unsure if they belong in counseling programs (Thacker & Minton, 2021). To that point, Presley Marie shared that eight of her 11 cohort members dropped out of their Ph.D. program due to intense discrimination and microaggressions. Such an experience reinforces the need for continued training and evaluation of counselor educators and the counseling program environment. In response to personal biases and ingrained systems of White and majority supremacy, counselor educators can attend professional workshops on implementing non-oppressive learning environments, engage in training on anti-racist teaching practices, and be open to suggestions from faculty of color to make fundamental changes to eliminate oppression in counseling programs.

Lastly, dispelling loneliness, the indeterminate sense of belonging, and searching for a place at the table comes with colleague support and mentorship. For example, Ellie mentioned that community was “incredibly important,” and without her closest colleague, she would have “quit a long time ago.” Other participants shared that support from White counselors was instrumental in not being solely tasked to call out racism or inappropriate behavior.

In a college setting, Tanesha noted that leadership in her college counseling center was instrumental to advocacy and a supportive environment. The other COCs in this study who worked in college counseling centers also described the leadership structure as more supportive and forward-thinking. COCs in this study that worked in hospital settings noted that the

leadership was less willing to discuss diversity concerns. The COCs felt less supported with their needs; thus, access to a mentor or peer consultation group is essential for COCs who work in less supportive environments.

Mentorship may be essential for increasing diversity and sustaining employment in the ED field. Consequently, leaders of professional counseling organizations may want to consider how to incorporate mentorship into membership benefits. For counselors who cannot afford professional organization memberships, ED clinicians ought to create mentorship programs for COCs. With the majority of seats taken by White counselors, it is their responsibility to dismantle the oppressive systems that create barriers for COCs, support COCs' efforts with research, adapt EBTs, and reduce barriers for POC.

Limitations

I recognize that this study, like all studies, has its limitations. Four primary limitations stand out to me for this study. The first limitation stems from an ambiguous classification of what constitutes specialization in EDs. Though all study participants had at least two years of treating EDs, some participants had limited training on treatment modalities for EDs. The tentative manifestation of feeling unprepared and the production of seeking culturally inclusive treatment inform one another. As many of the participants were young in the field, recruiting counselors with more years of experience and training may yield different findings.

Second, I recruited study participants through multiple channels; however, most participants accessed the study through CESNET, a counselor education email listserv. This platform is intended for communication by counselor educators and counselor education doctoral students, which explains why nine of the eleven participants were currently enrolled in doctoral programs. Initially, I saw this participant characteristic as a provocation; however, it also could

serve as a limitation because the identity of COCs in doctoral programs may differ from those of COCs not in doctoral programs. For example, doctoral students in counselor education focus heavily on conducting research. The participants in this study who were in doctoral programs discussed extensively the lack of research and the need to find research on EDs within marginalized communities. They also focused on educating others, supervising, and teaching more communities about EDs. Though these issues are critical elements of working in EDs, having masters-level clinicians as participants may have produced different study findings.

A third limitation was the data collection methods. Though one interview is not generally seen as a limitation in qualitative research (Hayes & Singh, 2012), when using PIP, it is encouraged to have multiple interviews and other material sources for analysis (Vagle, 2018). After conducting interviews with the first two participants, I realized there were other avenues of inquiry that I wanted to explore with participants beyond the questions I prepared in the interview protocol. The study design allowed me to send a follow-up email with a single question, which I utilized to gather more information about the participants' decisions to enter a doctoral program. However, after each interview, I felt a second interview would offer a deeper discussion about their experiences. Because I was limited to only one interview in this study, per my study plan, the data collected and findings may be less robust than they could have been with multiple interviews per participant.

One final and critical limitation of this study is my Whiteness. One potential participant shared that they would not feel comfortable with a White researcher, which hindered their opportunity for participation. Additionally, my Whiteness may have lessened the participants' comfort in answering interview questions, particularly about discrimination or working in White spaces. Although many interview questions were unrelated to race, questions that focused on

White spaces or discrimination felt delicate to balance for me to navigate with participants. I perceived that participants engaged in some editing of answers, lessening of strong adjectives, and limiting the information that might have been too personal to share. One participant returned their transcript with multiple additions of the term White supremacy, dominant culture, and oppression. These changes suggest self-censure in the original interview. Irrespective of how I broached my Whiteness or reassured participants that I wanted to hear about their unabridged experiences, being a White interviewer impacts participants' answers to some degree. Though I believe the study's findings are valid and beneficial, having a POC interview these COCs may offer additional findings related to their experiences with racism and discrimination.

Future Considerations

One of the purposes of conducting this study was to establish a foundation for future research in EDs that will bring about systemic and social changes. The first suggestion for research is to look further into what treatment modalities exist for EDs with a solid cultural focus or flexibility for cultural adaptation. EBTs such as CBT, CBT-Enhanced, and Family Based treatment (FBT) can be modified to include cultural elements. However, more specific treatments within these modalities should be developed and established as standard components of these treatments.

For social change, there is a need to educate people on EDs, how they present across all cultures, and how to recognize them. This research might start at the front lines with school counselors and their ability to offer psychoeducation and guidance lessons. ED awareness in school might help more people to identify disordered eating and offer them access to a school counselor who can refer them to appropriate treatment.

Additionally, researchers ought to focus on the outcomes of increased training and education of EDs in graduate school. Researchers might explore counselor self-efficacy for understanding or treating EDs after implementing a course specific to EDs, offering an ED workshop during a counseling program, or simply inserting more information about EDs into different courses. It would also benefit CITs to research specialty mismatches between supervisors and supervisees when working with clients with EDs. Such research could focus on increasing counselor educator supervisors' competency in supervising ED work in practicum and internship. This research may also offer insight into the ethical issues of a practicum student counseling a client with an eating disorder without proper supervision.

Lastly, research on the pervasiveness of ED counselors developing disordered eating and body image concerns would offer a clearer picture of the potential personal effects of working with this population. Looking at what protective factors ED counselors use to limit countertransference or reduce their risk of taking on aspects of disordered eating would illuminate ways clinicians can proactively minimize any risks. Along with this research, identifying any personal traits, beliefs, or experiences that made counselors more vulnerable to developing disordered eating and body image concerns can guide potential ED counselors and current ED counselors on being mindful in protecting themselves.

Conclusion

As PIP does not consider beginnings or endings, this conclusion is a continuation of thought. Considering my positionality as a White researcher, exploring the lived experiences of counselors of color created another phenomenon. My intentionality with the potential research was excitement, curiosity, and a strong desire to do meaningful work. Sans the email that almost derailed this study, I felt supported by everyone in my program and connected meaningfully to

the research. Through the process, my intentionality shifted across contexts, such as interview beginnings with each new participant, the end of those interviews, and responses to follow-up communications. My intentionality wavered at points when I was unsure of my ability to do justice to the participants' powerful words. With some participants, I felt drawn to their stories and connected instantly. Others, I perceived suspicion about my intentions and could feel my intentionality to the research unstable.

As I sorted out tentative manifestations, productions, and provocations, I felt unsuited to the task of naming experiences outside of my own. I reached out for support from my peer checkers and pushed through with their encouragement. Then as I began to write, I was drawn to the freedom PIP offered to share more of the participants' journeys through their words, entangled with my own feelings. My discomfort, at times, was less important than the knowledge now available in the field of eating disorders. Researching COCs as a White researcher was necessary, as limited research exists on COCs in EDs. Though I ardently support research done by whoever feels passionate about the topic, it remains my hope that by setting a foundation for this research, I can support my colleagues, who are POC, in continuing this vital work.

For this study, I focused on specific findings; however, many other valuable experiences are extractable. When considering the implications of this study, it appears that counseling students have a limited understanding of EDs, making the transition into working with this population complex. A counselor's ability to identify EDs depends on their training in graduate school and personal training once in the field. As eating concerns and body image are issues many people deal with, counselors are highly likely to have a client with disordered eating or an eating disorder in their careers (Levitt, 2006). As research on the presentation of EDs in POC is

limited, there is added concern that these clients will continue to be underdiagnosed and untreated.

COCs who choose to work in the ED field face additional challenges when working with POC. The complexity of EDs, the layers of cultural influences on such disorders, and the lack of culturally inclusive treatment for EDs contribute to exhaustion and a heavy load for the participants in this study. Though these COCs reported pushing forward with a strong sense of duty to their community, researchers in the ED field could focus on adapting EBTs to meet the needs of clients of color, thus alleviating the pressure on COCs to create and modify treatments themselves.

Increasing representation in the ED field may break down some barriers for POC seeking treatment. Some clients seek counselors that have similar racial backgrounds. As more COCs enter the counseling field, and EDs specifically, clients of color will have access to the treatment they need from the counselors they prefer. Additionally, with more COCs in the ED field, the image that EDs are solely a White woman's disorder may dissipate and bring more awareness to the pervasiveness of EDs in all communities.

Counselor educators must consider the needs of CITs, their future clients, and the counseling field. EDs are complex, dangerous, and highly difficult to treat (Franklin, 2020). Counselor educators need to prepare students for the eventuality of working with clients who exhibit ED behaviors and how to identify EDs, treat EDs, or refer clients out for additional support. When teaching about EDs, counselor educators must be aware of the different presentations of symptoms in various marginalized groups and educate CITs on using culturally appropriate treatments. For counselors in the field, counseling leaders and supervisors ought to intentionally include the voices of COCs and be mindful of relying solely on them to treat clients

of color or educate their peers on how to be culturally competent. Each counselor should continue to foster cultural competency and increase efforts to become more inclusive in research and treatment methods.

In this study, I attempted to bring awareness and systemic change to the ED field. After speaking with the COCs participants, I am changed. In some ways, their experiences in EDs resemble mine. However, in other ways, their experiences diverge into more challenging paths. The changes I have suggested due to their experiences may serve as essential steps towards necessary systemic change. In Chapter 4, I informed you that now you are part of the phenomenon of COCs experiences of choosing and working in the ED field. As there are no beginnings or endings in PIP, your choice of how you move forward with this knowledge will become a thread in the experiences of current and future COCs in EDs. What will you do with this knowledge?

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Appendix A: IRB Approval

To: Amy Biang Counseling
From: Office of Research Protections and Integrity
RE: Notice of Exemption with Limited Review Approval
Approval Date: 01-Nov-2022
Exemption Category: 2
Study #: IRB-23-0309
Study Title: Examining the Lived Experiences of Counselors of Color Working in the Eating Disorder Profession

This submission has been reviewed by the Office of Research Protections and Integrity (ORPI) and was determined to meet the Exempt category cited above under 45 CFR 46.104(d). In addition, this Exemption has received Limited Review by the IRB under 45 CFR 46.111(a)(7). This determination has no expiration or end date and is not subject to an annual continuing review. However, you are required to obtain IRB approval for all changes to any aspect of this study before they can be implemented and to comply with the Investigator Responsibilities detailed below.

Important Information:

1. Face masks are optional on UNC Charlotte's campus. This includes classrooms and other academic spaces. Researchers conducting HSR activities in other locations must continue to adhere to local and state requirements in the setting where the research is conducted.
2. Face masks are still required in healthcare settings. Researchers conducting HSR activities in these settings must continue to adhere to face coving requirements.
3. Organizations, institutions, agencies, businesses, etc. may have further site-specific requirements such as continuing to have a mask requirement, limiting access, and/or physical distancing. Researchers must adhere to all requirements mandated by the study site.

Your approved study documents are available online at Submission Page.

Investigator's Responsibilities:

1. Amendments must be submitted for review and the amendment must be approved before implementing the amendment. This includes changes to study procedures, study materials, personnel, etc.
2. Data security procedures must follow procedures as approved in the protocol and in accordance with OneIT Guidelines for Data Handling.
3. Promptly notify the IRB (uncc-irb@uncc.edu) of any adverse events or unanticipated risks to participants or others
4. Five years (5) following this approval, ORPI will request a study status update.

5. Be aware that this study is now included in the Office of Research Protections and Integrity (ORPI) Post-Approval Monitoring program and may be selected for post-review monitoring at some point in the future.
6. Reply to ORPI post-review monitoring and administrative check-ins that will be conducted periodically to update ORPI as to the status of the study.
7. Complete the Closure eform via IRBIS once the study is complete

Please be aware that additional approvals may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records).

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), where applicable.

Appendix B- Recruitment Email

Hello,

My name is Amy Biang. I am a doctoral student in the Counseling Department at the University of North Carolina at Charlotte. I am conducting a research study exploring the lived experiences of counselors of color working in the eating disorder field. We invite you to participate in this study if you are age 18 or older, identify as a person of color, and are a licensed counselor, social worker, or psychologist. You are eligible to participate in this study if you have worked with 5 or more clients in the past year with an eating disorder or are currently training to become specialized in working with this population.

If you agree, you are asked to participate in an individual interview, conducted and recorded over Zoom, for approximately 60 minutes. If you are interested in participating, click the Qualtrics link and complete the consent and short demographic questionnaire. The questionnaire will ask you to create a pseudonym that will be used in all communications. Once your consent is received, I will schedule your interview. Please contact Amy Biang at abiang@uncc.edu or 520-331-3796 for any questions.

https://uncc.qualtrics.com/jfe/form/SV_9t67uYY9lKUX2Hs

Thank you for your participation,

Amy Biang LCMHC, CEDS
University of North Carolina at Charlotte
Doctoral student, Counselor Education and Supervision

Clare Merlin-Knoblich Ph.D, NCC
University of North Carolina at Charlotte
Assistant Professor, Counselor Education

Appendix C: Informed Consent

At the interview, you will be asked to give verbal permission again to consent to be recorded. Upon completion of the interview, the video portion will be deleted, and the audio will be used for transcription through Zoom's transcription service.

Your time commitment will be about 60 min for the interview. If a follow-up interview is needed, it should be no more than 10 minutes. Once transcription is completed, you will receive an email asking if you would like to review your transcript for accuracy or to add additional information. If you consent, I will email the transcript to you, with the pseudonym in place of your name. **A reminder that email is not guaranteed to be secure**, however, your name is not associated with the transcript. You may also request a Zoom meeting with screen share to view your transcript confidentially. Additionally, you will be asked to answer one follow-up question that can be emailed back to Amy Biang.

We will also collect information on your training experiences, degree earned, and type of environment you work.

What are the benefits of this study?

There are no direct benefits to you as a participant in this study. However, information gathered from your experiences may help improve the diversity and inclusion needed in the eating disorder profession.

What risks might I experience?

There are risks involved in all research studies. This study may include only minimal risks. You may become uncomfortable when answering some questions. If you are uncomfortable at any point, you may take a break, move on to the next question, or end the interview.

How will my information be protected?

All data collected in this study will remain confidential. Electronic data will be accessed on a password-protected computer and stored on a secure cloud storage network. Your identity will be protected because a pseudonym will be used to identify you. No details about your place of employment will be collected other than the type of practice.

Once the interview is over and uploaded to the cloud storage, the video file will be deleted immediately. Only the audio file will be saved for transcription. Once all transcription is completed, the audio file will be deleted.

No email communications will be stored with any data from the interviews; however your email will be attached to your pseudonym. If you prefer to view your transcript through a Zoom meeting, I will set up a

screen share to guarantee confidentiality. However, the transcript can be sent over email, if you prefer, but is not a guaranteed to be protected.

We plan to publish the results of this study. To protect your privacy, we will not include any information that could identify you. We will protect the confidentiality of the research data by using pseudonyms for identification.
Other people may need to see the information we collect about you. Including people who work for UNC Charlotte, and other agencies as required by law or allowed by federal regulations.

How will my information be used after the study is over?
After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of publishing our results. The data we share will NOT include information that could identify you. Data will not be deposited in a repository.

Will I receive an incentive for taking part in this study?
The first 15 participants will receive a $15 Visa gift card by email once the interview is complete. The time stamp on the Qualtrics Survey will be used to identify the first 15 respondents. Participants will be told in the scheduling email if they are one of the first 15 respondents and eligible for the gift card. Gift cards are given only once the interview is complete. Those who do not participate in the interview are no longer eligible for the gift card.

What are my rights if I take part in this study?
It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you withdraw during the interview process, the recording will be deleted, and no information will be transcribed.

Who can answer my questions about this study and my rights as a participant?
For questions about this research, you may contact Amy Biang, abiang@uncc.edu, 520-331-3796 or the faculty advisor, Dr. Merlin-Knoblich, claremerlin@uncc.edu.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at uncc-irb@uncc.edu.

Consent to Participate

By electronically accepting this document, you are agreeing to be in this study. Make sure you understand what the study is about before you agree. You will receive a copy of this document for your records upon request. If you have any questions about the study after you complete this document, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I understand this interview will be recorded. I agree to take part in this study.

Appendix D: Qualtrics Demographic Questionnaire

Eating Disorder Counselors

Start of Block: Default Question Block

Q1

Consent to be part of a Research Study Title of the Project:

Exploration of the Lived Experiences of Counselors of Color Working in the Eating Disorder Profession

- ○ Yes, I consent to participate in the study (1)
- ○ No, I do not consent to participate in the study (2)

Skip To: End of Survey If Consent to be part of a Research Study Title of the Project: Exploration of the Lived Experiences... = No, I do not consent to participate in the study

End of Block: Default Question Block

Start of Block: Block 1

Q3 Thank you for your willingness to participate in this study. Please complete the following demographic questions. You may skip any question you prefer not to answer.

Q4 Please create a pseudonym that you would like to be used for the study. It can be any name you want.

_____

Q5 What is your self-identified race or ethnicity?

_____

Q6 What is your self-identified gender?

_____

Q7 What is your highest completed education?

_____

Q8 What is your professional identity? (e.g., counselor, psychologist, social worker)

_____

Q9 How many years have you been working with eating disorders?

_____

Q10 What type of environment do you practice at?

- ○ Private Practice (1)
- ○ Hospital (2)
- ○ Residential Treatment Center (3)
- ○ Day treatment or Partial Hospitalization (4)
- ○ College Campus (5)
- ○ Other (6) _____

Q11 Have you personally been diagnosed or felt you had an eating disorder at some point in your life?

- ○ Yes (1)
- ○ No (2)
- ○ Prefer not to answer (3)

Q12 Can you briefly describe what types of eating disorder training you have received. (e.g., workshops, conference sessions, self-guided reading, supervision)

_____

Q13 Please indicate the email address you would like to use for scheduling the zoom interview and any other communication pertaining to the study. (Your pseudonym will be used in all communication)

_____

End of Block: Block 1

Appendix E: Interview Protocol

Procedure

1. The researcher will introduce the interview procedure.
2. The participant will be informed that the interview will be audio/ video recorded.
3. When the participant verbally provides their consent, the recording will begin.
4. The researcher will ask the interview questions.

Interview Guidelines

Thank you for participating in this study. My name is Amy Biang. The purpose of this study is to explore the experiences of Counselors of Color working in the eating disorder field. I am going to ask you a series of questions. When I analyze and published the findings of this study, your name will not be used. Moving forward, there are no wrong answers, so please answer the questions as freely as you can. You do not need to answer any questions that you do not feel comfortable with. You may stop at any time for any reason. As a reminder, this interview will be recorded. Would you still like to proceed?

- If no, the researcher will stop the interview and ask whether the participant is willing to be interviewed at another time.
- If yes, the researcher will continue the interview and press record on the Zoom

Pipeline to be a Counselor in Eating Disorder Field

Covert Categories:

- How they begin the journey to becoming an ED counselor
- What role, if any, did a graduate school play in their journey to specializing in ED
- What role, if any, did post-graduate experience play in their journey to specializing in ED
- What relationships with other professionals are necessary to be in the ED pipeline

Warm-up Questions: Tell me a little bit about yourself.

Tell me about your current position.

What does a typical day at work look like?

Lead-off Question:

- What drew you to work with eating disorders?

Follow-up Questions:

- Tell me about any relationships that impacted your path into the ED field.
- Tell me about your graduate school experiences that influenced you in specializing in EDs.
- After graduate school, what experiences moved you towards training to work in EDs?
- In your view, what were the challenges and issues to starting work in EDs

Experiences While Working in the ED Field

(Engagement with other Professionals)

Covert Categories:

- How do they experience connections working in the ED profession
- How do they experience working with a complex/ difficult disorder
- What drives them to stay working with EDs

Lead-off Question:

- Please share a memorable experience working in the ED field.

Follow-up Questions:

- What is an unpleasant experience you have working in the ED field (if you are willing to share)?
- What challenges you in the ED field?
- Can you give me two adjectives that describe working in the ED field? Two emotions?
- What keeps you working with the ED population?
- What are your relationships like with other professionals in the ED field?

Experiences Being a COC in the ED Field

Covert Categories:

- How does race/ethnicity impact their connectedness to the ED profession
- How do they connect or not connect to the clients
- What is their perception of the diversity of EDs
- What experiences of racism have then endured

Lead-off question:

- How does your race/ethnicity influence your interactions with other professionals in the ED field?

Follow-up Questions:

- (First, explain racial/ethnic matching)- What are your experiences with racial/ethnic matching?
    - What are your experiences with working with clients of the same race/ethnicity as yourself?
    - What are your experiences working with clients of a different race/ethnicity than yourself?
- What is your experience of racial diversity in the ED field?
- Describe the myths, biases, or stereotypes have you had to face or overcome when working in EDs
- How, if at all, do you feel supported in your work as an ED counselor?
- How, if at all, do you feel oppressed in your work as an ED counselor?

Final Questions:

- How do you develop yourself professionally?
- What advice would you give students of color or new counselors of color about considering the ED field
- How can we increase representation in ED work?
- Is there anything else that you would like to add?