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"Not Just a White Woman's Disease": Radicalizing Eating Disorder Knowledge

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“Not Just a White Woman’s Disease”:
Radicalizing Eating Disorder Knowledge

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Abstract

Eating disorder knowledge is dominated by a homogenous perspective largely devoid of racial or cultural diversity. Dialogues about what it means to be a woman and what it means to have an eating disorder have historically been singularly situated within the bodies of white women. These predominantly white narratives have served as the foundation for research studies on eating disorders which have shaped knowledge related to eating disorder diagnosis and treatment. By comparing the narratives of black (n=20), white (n=23), and Latina (n=15) women with eating disorders as well as incorporating perspectives from fifteen clinicians who treat eating disorders, this thesis investigates how the diagnosis and treatment of eating disorders is reflective of white-dominated epistemological eating disorder frameworks which further marginalize women of color with eating disorders who interact with institutions of psychology and medicine. Eating disorder diagnostic criteria, as defined by psychological and medical expertise, are evaluated and compared to details shared by women about their eating disorder experiences. New knowledges about eating disorders according to the words of Latina and black women are proposed, integrating women's individual psychological experiences into the collective social and cultural experiences that inform women of color's eating disorders. The relationship between heterogeneous eating disorder knowledge and treatment accessibility is also discussed. This thesis concludes that in order for black and Latina women to access more equitable eating disorder diagnosis and treatment, the impact that collective social marginalization has on individual bodies must be integrated into clinical and academic knowledge related to eating disorders.

Key words: eating disorders; black women; Latina women; self-narratives; epistemology

Introduction

By clinical estimates, eating disorders (EDs) currently affect over 30 million people in the United States. EDs are amongst the most fatal psychiatric diseases, taking a life every sixty-two minutes (Eating Disorders Coalition, 2016; Hudson et al., 2007). The stereotypical image of an ED is a thin, young, white woman. This is because when most people think about EDs, they think of anorexia nervosa – a disease characterized by food restriction. However, EDs are diverse in their symptomatology and presentation, including symptoms such as self-starvation (commonly associated with a diagnosis of anorexia nervosa) bingeing (binge eating disorder and bulimia), consuming non-food items (pica), and purging (bulimia nervosa). EDs develop for many reasons which have been explored through psychological, psychiatric, neuroscientific, and biological research. Although the disease has a strong biological and genetic basis, EDs are also highly impacted by a person's environment and social world (Bulik et al., 1998; Bulik, 2004; Bulik, 2005). In fact, the term "eating disorder" is a misnomer, as it insinuates that the disorder is characterized only by a person's relationship to food. In reality, EDs serve as complex coping mechanisms that arise in response to various social and cultural factors. Many people turn to EDs as a way to achieve control in an otherwise unpredictable world, especially when working through experiences of racism, sexism, poverty, trauma, and other forms of distress.

EDs are associated with a demographic of young, white, middle or upper class cisgender women or girls. The prevalence of American diet culture has created an environment where girls are taught that thinness is the primary way they can receive social power. The thinner the girl's body, the more praise, popularity, and poise will be projected on to her. This scenario of achievement via thinness is the story that is told in movies, books, and TV shows depicting women with EDs. The protagonist of this narrative is likely to be a young, beautiful,

heterosexual white girl who can be described as a perfectionist with parents who pressure her to succeed. The hero of the girl's story is usually a doctor or therapist who guides her into recovery and self-actualization through re-feeding and therapy. This narrative has been told many times through various mediums, and continues to influence how EDs are understood within society. Most recently, this story was told in two well-financed films about EDs released in the summer of 2017 – *Feed*, and *To the Bone*. Although heavily critiqued, both films were lauded for initiating conversations about the seriousness of EDs. However, the conversations that arose were not radical or new. They did not offer any insight into what it is like to experience an ED in a body that is not white and privileged. Therefore, it is time to shed some light on how EDs are experienced by people who aren't young, white, or financially privileged. Their stories deserve to be heard and incorporated into what it means to have an ED.

EDs are not exclusively experienced by white women and girls. However, the majority of stories told about EDs are associated with white femininity. EDs have been constructed in reference to white body ideals, which are thought to most directly affect white women's experiences. The prevailing understanding of EDs as a problem of body image has led EDs to be understood in reference to an individual's relationship to food, aesthetics, and sexuality, rather than in terms of structural relationships of racism, poverty, and misogyny. Understanding EDs as an issue affecting white femininity makes EDs simpler, cleaner, and easier to understand. Focusing on thin white girls diverts attention from the uncomfortable reality of what it is like to live in a fat body, a brown body, or poor body in a racist, fat-phobic, capitalist society. Issues of racism and classism are left out of the conversation leaving behind an exclusively white female ED narrative. This ED stereotype does not acknowledge the fact that men also get EDs, as do older women, transgender folks, poor people, brown people, disabled people, and black people.

In order for more people—not just white women—with EDs to get better, these “non-traditional” ED sufferers are not only going to have to be accepted, but also integrated into how EDs are defined and understood within psychology and medicine.

Here, I will focus on two populations—Latina and black women—who often experience EDs but do not get recognized, diagnosed, or receive treatment for their EDs as often as white women (Gordon et al., 2002; Cachelin et al., 2000; O’Neill, 2003; Marques et al., 2011). By focusing on two non-white populations within the context of American society, I also enter into a conversation about the ways in which white supremacy prevails within dominant institutions of healthcare and mental health treatment. The ways in which these institutions can be redesigned so non-white women have access to more culturally relevant and sensitive treatment for mental illnesses such as EDs is also considered. This thesis is informed by the work of sociologist Becky Thompson, whose 1994 book *A Hunger So Wide and So Deep: A Multiracial View of Women’s Eating Problems* exposed the relationship between social marginalization and EDs through qualitative interviews with racially, culturally, sexually, and religiously diverse women. Not only did her work describe these women’s experiences, but it also incorporated marginalized women’s identities into ED epistemology. Over twenty years later, there is still much work to be done when it comes to integrating issues of race, ethnicity, and white supremacy into the institutions of psychology and medicine. I hope to re-ignite and contemporize the investigation that Thompson began, focusing specifically on the relationship between racial and cultural marginalization and EDs.

Stephanie and Gloria

In order to start challenging white-washed ED stereotypes, I present the stories of two women with EDs whose narratives defy traditional ED stereotypes. In her book, *Not All Black*

Girls Know How to Eat: A Story of Bulimia, Stephanie Covington-Armstrong recounts her experience as a young black woman with an ED. Although she struggled throughout her adolescence, Stephanie was in her early twenties when she first sought out help. While living in New York City, she participated in a psychology research study on EDs at a well-known hospital. However, she was not graciously welcomed into the study. When she arrived, the head researcher had to explain to her that she was “the first African American applicant [they’d] had in the program,” which was his way of justifying “his coworkers lack of professionalism.” Stephanie responded by wondering if she “should have confessed to bingeing on fried chicken and cornbread so [the researchers would] be able to find comfort in a stereotype” (Covington Armstrong, 2009, p.205). Immediately upon seeking out treatment, Stephanie’s identity as a black woman became a roadblock in her ability to access compassionate care.

Stephanie later attended anorexia and bulimia recovery meetings for support. Sitting in the meetings, feeling like “a melanin-enriched alien,” Stephanie listened to “an assortment of Daddy’s girls [whine] about their inability to stop throwing up or starving themselves to death” (Covington-Armstrong, 2009, p.211). The first time she got the courage to speak during a meeting, she spoke about “the isolation of being a poor black woman fighting bulimia” to “a room of white women.” After speaking, a woman who Stephanie described as a “a tall, lithe, well-dressed blond,” took the stage, stating “I don’t understand why I am slowly, surely trying to kill myself by throwing up. I have a great life, and I have never wanted for anything. I wish I were a poor black woman because then maybe this need to throw up my life would make sense” (Covington-Armstrong, 2009, p.212). Following that meeting, Stephanie relapsed—falling back into the only behaviors she knew would help her cope with the traumas she had experienced, which were triggered by the woman’s words. No matter how much she wanted to recover,

Stephanie knew that she would have to fight for others to understand her experience. This was exhausting, and led her to rely even more heavily on her ED behaviors as a way to cope with the lack of control she had over how others perceived her.

Gloria Lucas, a Mexican-American woman, developed an ED around the same age as Stephanie. Like Stephanie, when Gloria attempted to seek out care, she did not feel comfortable within the treatment settings that existed close to her. Although she lived in an area with multiple ED treatment centers nearby, Gloria could not attend any of them. There were important logistical barriers that kept Gloria from receiving care, such as her long work hours and inadequate health insurance. However, Gloria also clarifies that ED treatment was “not in [her] language.” Gloria perceived that treatment centers were “only for people who can afford to go to some Malibu recovery white clinic,” which would just “fuck [her] up more” (Harrison, 2017). Through examining her own experiences as well as the experiences of other people of color, Gloria noticed a pattern when it came to people of color’s interactions with healthcare professionals. This led her to eventually conclude that “nobody cares about our health. Nobody cares about women of color with eating disorders. Period. And I think that we need to admit that nobody cares” (Harrison, 2017).

Gloria realized that she could not rely on the types of ED treatment that existed around her to help her find healing. Instead, she began advocating “home based recovery within family and friends,” focused less on dominant healthcare institutions and more on community issues that affect people of color’s bodily experiences. This eventually led Gloria to found an organization called Nalgona Positivity Pride in 2014, which she describes as a “Xicana-Brown-Indigenous project that focuses on intersectional body positivity, eating disorder awareness, and cultural affirmation” (Nalgona Positivity Pride, n.d.). Gloria’s work as an activist and supporter

of people of color with EDs led her to also create Sage & Spoon – “an online support group for indigenous people and people of color with eating problems” (Sage and Spoon, n.d.). According to Lucas, healthcare institutions such as medicine and psychology do not have the knowledge base to understand and incorporate issues of race, acculturation, post-colonialism, and misogyny into ED treatment. Therefore, these institutions don’t understand the experiences of women of color with EDs, whose EDs and mental wellbeing are intrinsically tied to their experiences of social inequality.

Stephanie and Gloria both felt rejected by the psychological and medical resources which are meant to help diagnose and treat individuals with EDs. Due to their racial, ethnic, and cultural identities, both women felt they were unable to benefit from traditional ED care. Although time and money were also large deterrents to receiving treatment, racism and cultural insensitivity were at the root of why Stephanie and Gloria did not receive the care that they needed. Stephanie and Gloria both attempted to interact with institutions utilizing psychiatric and psychological treatment methods; however, those institutions have yet to integrate experiences of social marginalization into how they diagnose and treat EDs. As one black clinical psychologist explains— “psychology, in my opinion, does not offer critical theories and models of race and racism” (Clinician #15). Although Stephanie and Gloria’s racial, ethnic, and cultural identities determined how they experienced and sought out treatment, those aspects of their identities were ignored by the medical and psychological clinicians they interacted with. As one white clinician admitted while pondering why issues of marginalization have yet to find their way into diagnosis and treatment—“when race, gender, and class get involved, everyone gets all wonky” (Clinician #8).

The foundation of this thesis lies in the words of women who have spoken out about their experiences with EDs, as well as the perspectives of individuals who have been trained to heal these women. Based on the stories that I have read written by women of color about their own experiences and the interviews I have completed with clinicians who work in the field of psychology, I argue that that in order for socially marginalized individuals, specifically women of color, to actually benefit from the institution of psychology, a more nuanced understanding of race, ethnicity, gender, and historical oppression must be infused into ED epistemology. The discipline of psychology in particular must acknowledge and incorporate the lived experiences of marginalized women with EDs into institutional knowledge in order to achieve more equity in who benefits from mental healthcare resources. It is only when women's lived experiences are incorporated into the diagnosis and treatment of EDs that black and Latina women will benefit from psychologically dominated institutions of ED diagnosis and treatment.

Chapter Summaries

Chapter one outlines the history of EDs within the United States and reviews academic research on women of color and EDs. Chapter two describes the theoretical framework in which my argument is situated and outlines the specific methodology and coding processes used to analyze the data. Personal narratives written by white, black, and Latina women were analyzed alongside interviews with clinicians who treat EDs. I considered women's stories alongside clinician perspectives to help me draw conclusions about why black and Latina women feel unsupported by and unsafe within the institution of psychology, even though clinicians may be aware of and working to eliminate treatment inaccessibility.

Chapter three explains how the diagnostic criteria for EDs outlined in the most current *Diagnostic and Statistical Manual (DSM-5)* do not align with how black and Latina women

describe their experiences of EDs. White women's experiences aligned more with the individualistic definition of EDs present in the DSM, which may have contributed to the fact that white women in this sample were more likely than black and Latina women to have been diagnosed with an ED by a clinician. A lack of exposure to issues of diversity and multiculturalism through pedagogy and/or clinical practice meant that the clinicians in this sample did not have a thorough understanding of the relationship between EDs, ethnicity, race, and culture. This explained one of the driving factors behind why black and Latina women may not receive ED diagnoses as frequently as white women, which exacerbated the fact that they feel they do not deserve to receive medical or professional care for their ED.

Chapter four redefines EDs outside the confines of individualistically-oriented psychological diagnostic criteria. EDs are defined in terms of collective body knowledges that stem from experiencing institutional oppression, racism, misogyny, trauma, and acculturation. Black and Latina women in this sample described their EDs as coping mechanisms in response to historical, racial, sexual, and socially-rooted traumas. White women, in comparison, were more likely to describe their EDs in terms of individual suffering, such as describing their ED as an abusive male partner. Most clinicians understood EDs in terms of this individual framework. Only one white clinician brought up the relationship between trauma, misogyny, poverty, racism and EDs, although when asked directly, almost all clinicians felt it was important to incorporate issues of racism into ED treatment with minority women. In comparison, all the clinicians who identified as people of color discussed how collective trauma interacted with EDs in their interviews. Therefore, psychological epistemology, as it currently stands, does not integrate an understanding of how collective experiences inform the individual experience. Clinicians of color rely heavily upon their lived experiences as to inform their psychological

expertise. Most white clinicians do not have the ability to tap into these same types of experiential knowledges related to race, ethnicity, and culture, leaving them ill-equipped to comprehensively diagnose or treat Latina or black women with EDs.

Chapter five describes how issues related to race, ethnicity, and culture can be integrated into ED diagnosis and treatment, focusing specifically on the idea of treatment accommodations. Black and Latina women's interactions with healthcare mirrored the collective discrimination that they have faced within society. ED care was found to be inaccessible for black and Latina women due to financial and logistical reasons rooted in class and socioeconomic status. However, treatment was ultimately inaccessible due to a lack of trust between white-dominated institutions and communities of color that became apparent when black and Latina women attempted to interact with clinicians and other treatment providers. In order for women of color to not only access psychological and medical treatment but also feel comfortable seeking out those resources, the cultural values of black and Latina women must be represented within these institutions. Currently, this can only be achieved if diverse ED treatment providers are available to individuals seeking out ED treatment.

The three empirically-based chapters focus on communicating how ED knowledge exists within a white social universe dominated by a perspective of psychological individualism (Smith, 1972, p.13). Collective knowledges related to women's experiences with acculturation, racism, and misogyny work to more appropriately address the experiences of EDs described by non-white women. When black and Latina women entered into the institution of psychology, individualistically-oriented knowledges did not reflect how they live in their bodies within a white-supremacist American society. Although resource-based accommodations would benefit non-white women with EDs significantly, these class-based accommodations alone will not work

to directly address the existence of racism and white supremacy within treatment settings. By incorporating a more thorough understanding the social world into ED diagnosis and treatment, this thesis describes why black and Latina women's experiences do not fit into the objective, individualistically-oriented scientific knowledge claims of EDs. Women of color's perspectives reveal that the institutions of psychology and medicine must work to incorporate knowledge which recognizes the relationship between gender, race, and culture. These knowledges must be present within ED epistemology to allow all women with EDs equal access to resources for recovery and healing.

Disclaimers

I feel it is important to offer a disclaimer regarding the nature of my argument and its eventual focus on the identities and actions of clinicians who treat women with EDs. In order to fully address why non-white women are not receiving equitable treatment for their EDs, it became vital for me to point out how the racial homogeneity that currently exists within ED treatment is problematic and representative of how institutions of medicine and psychology continue to benefit from white supremacy (Marques et al., 2011). However, I do not want my observations to be misunderstood as calling white clinicians racist or white supremacist themselves. White clinicians did not ask for their privilege. But just because white clinicians did not acquire their privilege on their own does not mean that they do not need to confront how their privilege has benefitted them and hurt marginalized individuals. All of the clinicians I interviewed are noble individuals who work tirelessly with one of the most difficult to treat populations. However, I know that it would have been impossible and irresponsible for me to ignore the fact that I struggled to find clinicians to interview for this project who were not white cis-gender females. What that experience spoke to was not only the history of EDs and their

alignment with white femininity, but also the fact that racism is perpetuated within ED communities even though they are filled with hardworking, well-meaning people who work every day to heal sick bodies and minds.

The second disclaimer I'd like to offer relates to the fact that this thesis focuses on two specific populations who are part of a larger group of marginalized individuals suffering from EDs. Although the women in this study are relatively diverse in their racial, ethnic, and sexual identities, socioeconomic statuses and education levels, the lack of trans and non-binary individuals present within the sample is problematic and important to consider, especially when assessing the generalizability of this research. Although the black and Latina women included in this sample did not receive the same level of quality ED care that white women did, they were predominantly privileged when it came to their gender identity. Since it will not be the focus here, I wanted to take the time to emphasize that individuals who identify as LGBTQ are at a higher risk for developing EDs. Therefore, research must continue focus the relationships between, cis-normativity, hetero-normativity, and EDs if we hope to achieve a world in which all people have an equal opportunity to recover (Lyons, 2017).

Chapter 1: Background & Literature Review

EDs have been defined in terms of psychological and medical expertise. Here, I will outline the history EDs, focusing specifically on the relationship between EDs and the institution of psychology, to emphasize the close relationship between EDs whiteness, social status, and institutionalized knowledge. I will then summarize the current psychological research that has investigated the relationship between race, ethnicity, and development and experience of EDs, explaining how the present research adds to the existing literature on the topic.

The Historical Development of Psychological Knowledge About EDs

In the late 1800s, mental diseases were first identified and defined by French, British, and American male doctors. It was during this time that the official diagnosis of anorexia nervosa – the only known ED at the time— was created (Brumberg, 1988). Anorexia nervosa was formally recognized by two physicians in 1873, around the same time a French psychiatrist named Charles Laségue also described the disease (Brumberg, 1988). Anorexia was understood according to the experiences and perspectives of white male “high status practitioners” who largely held sexist expectations of women that informed their characterization of the disease (Brumberg, 1988, p.99). Anorexia nervosa was known as a phenomenon experienced by white, high-status women, simply because those women had access to these elite doctors. Therefore, doctors understood EDs as a response to lack of parental attention, which was thought to be a common source of psychic dysfunction amongst the wealthy (Brumberg, 1988).

Knowledge related to EDs has been relegated to the domains of psychology and psychiatry, whose institutional histories are dominated by white epistemological frameworks which were popularized and disseminated within the context of Western culture. The creators of this foundational psychological knowledge, which directly affects how EDs are understood

today, were all white men. The most well-known of these men, Sigmund Freud, first came to the United States in 1909 when he presented his theories in front of crowds of academics at Clark University (Bakalar, 2011; Illouz, 2008). Freud's theories on the "self" impacted the trajectory of the social world in 20th century America. According to Eva Illouz in *Freud: A Cultural Innovator*, there are various reasons why Freudian psychoanalysis succeeded at injecting itself into mainstream 20th century American culture. Freud not only held significant "charismatic authority," but his introduction to American culture was also extremely timely. During a time when society was searching for an understanding of individual identity, Freud offered answers by bringing together the fields of psychology, neurology, psychiatry, and medicine. Freud also possessed a network of devotees which allowed him to quickly spread his ideas (Illouz, 2008).

Freud also arrived in the United States when psychology was already a widely accepted and utilized discipline. Freud's connections to elite institutions aided in granting legitimacy to his ideas. The establishment of the New York Psychoanalytic Society in 1914 provided an even broader institutional framework to implement Freud's ideas into the American culture. According to Illouz, "Freud formulated new cultural codes that could make sense of the transformations family, sexuality, and gender relationships had undergone during the second half of the nineteenth century and provide new interpretive frames to organize these transformations" (Illouz, 2008, p.35). The emergence of media industries also aided in the dissemination of Freud's theories. Through Hollywood films, the image of the therapist and the therapeutic narrative of the self was explored. Advertising also took advantage of the growing field of psychology to create a link between commodified objects, social status, and individual identity (Illouz, 2008).

Psychological thought permeated society in the early 20th century, creating a monopoly on the idea of the self. However, psychology was not the only institution that has historically framed an understanding of the relationship between food, the body, and the self. Although the first official *Diagnostic and Statistical Manual* was published in 1952, doctors and psychologists had been creating names for groups of deviant behaviors present within populations for over 2,000 years (APA, 1952; APA, 2017). The symptoms that we now understand to be associated with anorexia nervosa were documented as early as the 1200s, when saints like St. Margaret of Cortona wrote about religious asceticism through self-starvation. In a letter by St. Margaret written in the 1200s, she explains that “I have no intention of making a peace pact between my body and my soul, and neither do I intend to hold back. Therefore, allow me to tame my body by not altering my diet; I will not stop for the rest of my life, until there is no more life left” (Hornbacher, 1988, p.126).

During the time of St. Margaret there were numerous documented cases of medieval female saints starving themselves in the name of God. Emile Durkheim’s work on the nature of religion in society provides an explanation for the importance of understanding the relationship between religion and female starvation. Durkheim explained that religion, and the spiritual forces that it espouses, is an essential component of human identity formation – a channel through which individuals forge connection and work to understand their own existence (Garrett, 1995). Starving saints, therefore, attempted to forge divine connections through the vessel of their body. By denying themselves the bodily pleasure of food –a mortal sin– starving saints became closer to achieving a personal relationship with the divine. This personal relationship was highly individualistic, focusing on a connection between a woman and God.

Rituals of self-starvation were medieval women's attempts at understanding their identity and sense of self. The norms of European society, being religiously based, meant that self-control through asceticism was one of the only ways that women could become worthy in the eyes of God as well as society (Garrett, 1995). A social constructivist view of anorexia nervosa and the female body suggests that women's bodies were expressing socially constructed gender norms of the times (MacSween, 1989; Brumberg, 1988). During the Victorian era, European women of status used food to communicate their adherence to social norms regarding femininity and virtuousness. Since women were expected to be passive, restrained, and dainty, women's appetites for food, sex, or other bodily pleasures were encouraged to be ignored. In compliance with these societal norms regarding morality and spirituality, women refused to eat (Brumberg, 1988). Women's pale, thin, and delicate bodies demonstrated to onlookers that they had the ability to resist temptation, and did not need to nourish themselves enough to perform the physical tasks reserved for men.

The 20th century saw the popularization of anorexia nervosa as a psychological disease afflicting elite women after the disease was first pathologized in the late 19th century. In 1978, psychiatrist Hilde Bruch published *The Golden Cage*, based on seventy case histories of female patients with anorexia nervosa. The demographics of ED sufferers had remained the same as when the disease was first described a hundred years prior, which Bruch explains at the beginning of her book by stating: "new diseases are rare, and a disease that selectively befalls the young, rich, and beautiful is practically unheard of. But such a disease is affecting the daughters of well-to-do, educated, and successful families" (Bruch, 1978, p.1). Bruch's book, written to reveal the nature of anorexia nervosa to lay audiences, impacted the public's understanding of

how EDs are experienced, and who experiences them. Bruch's book also outlined the rise of EDs in the context of modernity.

The rise of the modern culture industry, mass production, and marketing led to the propagation of the body as a consumer product (Horkheimer & Adorno, 1944). EDs became the epitome of a modern disease, rooted in capitalism and marketing which implanted conflicting desires of slimness and surplus into the psyche of post-World War I America (Alpern, 1990). Before the war, American attitudes towards spending were frugal, leading to a lack of demand for products. Marketing agencies therefore needed to find a new way to motivate buyers (Rossini, 2015). Their answer was found in the increasingly popular psychoanalytic theories brought to America by Freud. These ideas were disseminated into the popular consciousness by Freud's disciples—people like Edward Bernays and Ernest Dichter, who revolutionized the advertising industry by infusing psychology into it (Illouz, 2008; Rossini, 2015). Bernays, known as “the father of public relations,” promoted products as status symbols, or objects that represented a buyer's identity. Beauty, therefore, was re-branded as success, making the body the “finest consumer object” (Rossini, 2015).

Experiences of self-alienation began to manifest themselves through the production of products such as diet pills and anti-aging creams. Advertising became a tool used to perpetuate the idea that people's bodies, specifically women's bodies, were commodified objects to be manipulated into fitting an ideal figure. When advertising boomed, women's bodies were attacked. New “diseases” like cellulite began to appear on the pages of *Vogue*, encouraging the purchase of products such as anti-cellulite creams (Rossini, 2015). The dieting industry eventually rose to be a 586-billion-dollar industry, serving as the 20th century's most prominent example of capitalist success (Rossini, 2015). The rise in dieting that began in the early 1920s

allowed women to exert control over their bodies by buying into the new market of diet foods and weight loss drugs. This normalized food manipulation as a mechanism through which to achieve society's ideal form (Schawrtz, 1986). As dieting became more accessible, mass media expanded, and magazines such as *Shape* (1981), *American Health* (1982), *Superfit* (1985), and *Health and Living* (1985) became widely accessible, rates of EDs increased. Between 1988 and 1993, incidences of bulimia nervosa tripled in the United Kingdom – quickly following the creation of women's magazines such as *Elle*, *Marie Claire*, and *New Woman* (Currin et al., 2005; Gough-Yates, 2003). Today, idealized images of slim bodies, dieting advertisements, and food commercials saturate Western culture.

By the end of the 20th century, the prevalence of EDs was increasing. The rise in diet culture and media attention on EDs led to a heightened awareness of EDs. When American singer Karen Carpenter died in 1983 weighing only 90 pounds, the American public became more aware of the lethal yet inconspicuous disease (Latson, 2016). During a time when most people believed that supermodel Twiggy had the ideal body, Carpenter's death made many realize that being too thin could kill you (Latson, 2016). When Princess Diana spoke out about her struggles with bulimia nervosa, an even less understood and recognized ED, conversations about EDs became more complex, although they still were being presented as affecting the same demographic of white, "well-to-do" women (Mendle, 2017).

As the diet industry boomed and rates of EDs rose, feminists began working to challenge Western culture's endorsement of female self-starvation. Feminists recognized that the societally-endorsed starvation of female bodies was yet another way in which the patriarchy was working to gain control over women's bodily autonomy. When Susie Orbach declared that "fat is a feminist issue" in 1978, she spoke on behalf of a movement of feminists fighting against the

oppression of the female body. She was specifically referring to the oppressive nature of female body ideals and the normalization of dietary restraint. In her book, *Fat is a Feminist Issue*, she declared that “fat is an adaptation to the oppression of women, and, as such, it may be an unsatisfying personal solution and an ineffectual political attack” (Orbach, 1978, p. 22). She described the experiences of compulsive eating among women who react to their oppression by stuffing themselves, making themselves fatter and less desirable according to the male gaze. She described that “fat is about protection, sex, nurturance, strength, boundaries, mothering, substance, assertion, and rage. It is a response to the inequality of the sexes” (Orbach, 1978, p.7).

Although Orbach describes binge eating—a behavior on the other end of the spectrum from anorexia nervosa—her arguments are linked to the ways in which women dating back to medieval times also used food and their bodies to react to gendered cultural norms. However, Orbach’s discussion of binge eating articulated a different type of ED, which was described as a reactive performance of suffering and an attempt at self-protection, rather than a passive act of starvation and silence. Since her book was published, countless works of feminist epistemology have been written with the goal to understand why and how EDs develop in women. These perspectives can be summed up in a quote from Naomi Wolf’s 1990 book *The Beauty Myth*—“a culture fixated on female thinness is not an obsession about female beauty, but an obsession about female obedience. Dieting is the most potent political sedative in women’s history; a quietly mad population is a tractable one” (1991, p.187). In other words, feminists believe that dieting and EDs work to silence women attempting to break out of the confines of patriarchy and social subordination.

Discussions of female EDs rooted in feminism have continued to be integral to the understanding of EDs in society. However, the creation of diagnostic criteria for bulimia, binge

eating disorder (BED), and other EDs is what ultimately led to an increase in diagnosis and treatment. Before the 1980s, anorexia was a largely unknown disorder outside the walls of European and American asylums. For almost one hundred years, anorexia nervosa was also the only ED diagnosis, since bulimia nervosa did not appear in the DSM-3 until 1979 (APA, 1979). In 2013, BED was added to the DSM-5, making it the third official ED diagnosis. Before then, clinical cases of binge eating were classified under the diagnosis of “eating disorder not otherwise specified (EDNOS),” which was more recently been changed to “other specified feeding or eating disorder (OSFED)” in the DSM-5 (APA, 2013). These diagnoses, derived from the more traditional ED diagnoses of anorexia and bulimia, grew out of assumptions about what it means to be a white female, since EDs were first observed in European and white American women. Only in the early 1990s did researchers begin to investigate how people other than white women could be affected by EDs.

The Current State of Clinical Knowledge About Women of Color and EDs

Although the history of EDs is a history of female suffering, this story does not address the experiences of all women. In fact, it only addresses a very specific and privileged group of women – white, mainly heterosexual, socioeconomically privileged, educated, and predominantly Christian women. Women of color have been dismissed and misunderstood within dominant conversations about food, EDs, and the feminine body. Although it is known that over 30 million people in the United States are affected by a clinical ED at some point in their lifetime, the National Eating Disorders Association stated as late as 2016 that statistics on the prevalence of EDs in women of color were unavailable (NEDA, 2016). Since then, research on the topic has increased, however there has yet to be enough psychological or public health

research to produce well-informed statistics about how many women of color are affected by EDs, which speaks to the lack of concern and understanding of their experiences.

Incidence Rates & Estimates

Whether it is due to the increased exposure to Western media amongst diverse populations or a heightened awareness to the signs and symptoms of the illness, EDs have become more common within populations who have historically not been diagnosed with the disease. In a 2014 study conducted in Australia – a country with similar ED demographics to the U.S.— ED behaviors were found to have increased “most rapidly from 1998 to 2008 in those demographic sectors that were previously characterized as being less eating disordered,” such as in individuals who live below the median household income, men, and people over the age of forty-four (Mitchison et al., 2014, p.5). In the United States, research has also pointed to an increased prevalence of EDs in non-traditional populations. A 1995 study found that the frequency of eating disturbances among Hispanic (Latina) women was similar compared to frequencies of eating disturbances in white women (Crago et al., 1995). In another study which sought to examine ethnic diversity in "prevalence, correlates of functional impairment, and service utilization for past year and lifetime eating disorder diagnosis in a nationally representative sample," results found no significant difference in the prevalence of bulimia and anorexia amongst white, Latino, Asian, and black men and women (Marques et al., 2011, p.412). A study by Pike et al. (2001) even revealed that black women were diagnosed more frequently than white woman with binge eating disorder, while Marquez et al. (2011) found that bulimia nervosa was more prevalent among Latinos and African-Americans when compared to a white sample.

Hypotheses Related to Black and Latina Women with EDs

Only in the last thirty years have Latina and black women begun to be integrated into psychological research studies on the development and experience of EDs in women. Historically, the “buffering hypothesis” has been used to explain that women of color are protected from developing EDs due to the culturally bound nature of the disease and its roots in white body ideals. This hypothesis has deterred investigations into non-white women’s experiences with the disease. For example, Warren et al. (2005), found that ethnicity was a “protective factor against internalization of a thin ideal and body dissatisfaction,” with Mexican-American and Spanish-American women (p.241). European-American participants, who were presumably of Northern European descent, showed higher levels of thin-ideal internalization body dissatisfaction. These results, according to the researchers, supported the hypothesis that Mexican and Spanish-American women are protected against the impact of white, Northern European ideals of beauty since they did not exhibit the same levels of body dissatisfaction as white women.

Pike et al. (2011) found that black women with binge eating disorder (BED) exhibited less body dissatisfaction when compared to white women, despite the fact that black women had equally or slightly more severe symptoms of BED. Therefore, black women were assumed to be “buffered” from the effects that white body ideals have on individual body image. This allowed women of color’s ED experiences to be ignored under the pretense that they are not as heavily affected as white women by body dissatisfaction. The fact that national statistics on Latina women with EDs remain unavailable, “since as a group [they] are not the focus of large-scale research studies on the issue” indicates that Latina women’s experiences of EDs also aren’t taken as seriously as those of white women (Molinary, 2007, p.208). This claim stems from the idea

that Latina women are protected from white ideals because Latinos as a community also favor larger, more “curvy” body types. However, the idea that black and Latina women are “buffered” from EDs wrongfully represents the diseases as rooted in aesthetics rather than linked to experiences of collective trauma and white supremacy.

The claim that women of color, and especially black women, are protected from white, Western cultural ideals, serves “to defend and maintain a stratified social order by obscuring black women's experiences of suffering, acts of desperation, and anger” (Beauboeuf-Lafontant, 2009, p.2). By saying that women of color don’t suffer in the same ways that white women do, this means that they don’t need to be treated. The buffering hypothesis, when applied to black women, is reminiscent of the race-based fallacy that black women can’t feel pain, or at least not in the same way that white women do. Studies have shown that doctors perceive black women’s pain tolerance to be higher than that of white women (Hoffman et al., 2015). Black patients are also less likely to be given pain medications when reporting the same level of pain as white patients (Todd et al., 2000). The same racial bias apparent in medical treatment is present within the diagnosis and treatment of EDs. According to a study completed by Gordon et al. (2006), clinicians and doctors are less likely to diagnose women of color—specifically black women—with EDs. The study claims that white women were “assumed to be more vulnerable” to developing EDs “because of their desire to achieve American ideals of thinness.” Black women, in comparison, “are viewed as largely protected from eating disorders, as a result of their culture’s acceptance of larger body types” (Gordon et al., 2006, p.320). Therefore, the idea of social buffering can lead clinicians to overlook the experiences of women of color.

Many studies have specifically sought to compare EDs in white and black women. Most of these studies conclude by stating there is a need for more clinical research to support racially

diverse women with EDs, whose symptoms may differ from white women's (Pike et al. 2001; O'Neill, 2003; Striegel-Moore et al. 2003). Seldom do these studies explain why their symptoms may differ, failing to theorize the sociocultural and sociohistorical racial marginalization that serves as the foundation for these differences. The same can be said for studies incorporating Latina women. However, issues related to acculturation and immigration are commonly included in studies, claiming that Latina women desire to approximate the white body ideal through their ED behaviors (Neyland & Bardoan-Cone, 2016; Franko et al. 2012; Warren et al. 2010; Ferrari et al. 2009).

In a study investigating relationship between food, acculturation, and power in a sample of ethnically diverse women, Cheney (2011) noted that:

“Immigrant women who feel marginalized from the dominant white culture and are distanced from their native culture (or parents' native culture) use their bodies—which can be cultivated to embody core dominant values and thus heighten one's social status and increasing power—to gain social acceptance and obtain a sense of belonging. Molding their bodies into a slender ideal that symbolizes prestige and status permits women to retool their identities and bolster their self-worth” (p.1356).

Relatedly, Warren et al. (2010) found that Latina girls reported the highest levels of social comparisons to models, perceived appearance pressure, thin-ideal internalization, and eating pathology when compared to white and black participants. For Latina girls and women in this study, higher generational status was associated with increased ED symptoms (Warren et al., 2010). Psychological research seems to suggest an desire for Latina women especially to be like white women, which is linked to the supremacy of whiteness within body image research and society at large. White ideals are treated as superior, and therefore all women must desire to resemble them. However, this hypothesis contradicts the buffering hypothesis meant to explain why Latina women are protected from developing EDs. This contradiction likely arises because

research has only situated Latina women's EDs in comparison to white women's experiences, leaving the independent meaning of EDs in Latina women undertheorized.

Access to Diagnosis and Treatment

Due to the lack of recognition and representation they have received, people of color have been shown to not rely upon traditional forms of treatment to help them recover or heal from EDs. In a study by Cachelin et al., (2000) researchers sought to uncover why minority women with eating problems did not seek treatment, even when it was prescribed to them. Although sixty-six percent of the women in their diverse sample had been prescribed treatment by their doctors for weight problems mostly due to binge eating, only eight percent of women received treatment. A similar study by Striegel-Moore et al. (2000) also found that when compared to white women, black women were significantly less likely to seek out treatment for binge eating disorder. Systemic barriers such as financial difficulties, insurance coverage, counselors not being of the same ethnic background, and lack of transportation were found to be significant factors that led to women's lack of care, alongside social barriers including fears of being labeled, shame, fears of discrimination, and not thinking they have a problem (Cachelin et al., 2000).

Reyes-Rodríguez et al. (2013) also investigated factors that impact how Latinos engage in and maintain treatment for EDs. In the study, qualitative interviews with clinicians and patients revealed that Latinos were deterred from treatment due to factors including immigration stress, treatment experience in the U.S., barriers to help seeking, treatment needs, and issues with treatment retention. Family support was also found to be an important predictive factor of recovery within treatment of EDs within Latino populations. Although studies point out the institutional and cultural barriers that lead minority women to not access care, they do not make

space to discuss why those institutional barriers exist, and what role they play in maintaining the social subordination of minority women as a whole.

The Need for New Epistemologies

In *A Hunger So Wide and So Deep*, Becky Thompson described why it is important to understand women's eating problems in terms of race, ethnicity, socioeconomics, religion, and sexuality. "Women with eating problems," she wrote, "offer special insights about body consciousness because they respond to trauma in particularly bodily ways. Their stories reveal how bingeing, purging, and dieting can change a woman's embodiment, and they provide vivid examples of what it means for a woman to 'leave her body.' Leaving the body is a survival strategy many women use when they see no other alternatives" (1994, p.21). Thompson's work focused on women's eating problems as manifestations of their trauma, rather than "self-inflicted obsessions developed by young women lost in their own worlds of fashion and calorie counting" (1994, p.4). Her in-depth interviews with eighteen white, black, and Latina women directly challenged the notion that non-white women are protected from EDs. She explained that "the culture-of-thinness model has also been used, erroneously, to dismiss eating problems among women of color based on the notion that they are not interested in or affected by a culture that demands thinness" (1994, p.9). Her work described why EDs are a logical response to collective trauma, and advocated for a more sociological and less psychological perspective of EDs.

There has yet to be a body of work that has expanded upon Thompson's work on marginalized women's eating problems. In an era of abundant representations of EDs through T.V. shows, movies, and on social media, women of color with EDs are not adequately represented, even though nascent research has revealed that EDs are prevalent in women of color. The lack of media and research representation, along with the negative experiences

women of color describe having with psychologists and doctors, has left women of color with EDs to suffer on their own, without the same resources afforded to many white women.

In a study by Alegría et al. (2007), researchers concluded that "standard eating disorder criteria may not be appropriate for understanding psychological morbidity of EDs for Latinos, particularly less acculturated Latinos" (p.1). Similar findings related to ED diagnostic criteria and minority women were described by Striegel-Moore et al., (2003) who found differences between the experience of binge eating disorder when comparing white and black women, with more white women fitting traditional diagnostic criteria for binge eating. Traditional ED diagnoses, which are based off the experiences of white women, did not fit the experiences of black women with binge eating disorder or bulimia. Taken together, these studies ultimately provide evidence to support the idea that diagnostic criteria for EDs developed for Western populations may not function to properly diagnose or treat Latinos.

Although non-inclusive diagnostic criteria may be part of the reason why women of color do not receive ED diagnoses, perceptions of cultural behavior may also be contributing to the normalization of eating disordered behaviors within the context of psychological knowledge. In a study comparing the tolerance of mental health treatment stigma in Latina women with and without EDs, many Latinas who met criteria for BED or OSFED did not self-label their experiences as disordered, which the authors attribute to the "normative" nature of binge eating "in Latin cultures largely due to the cultural emphasis on food" (Higgins et al., 2016, p.1033). Latina women's experiences of binge eating were understood within an alternative cultural framework, emphasizing how their experiences did not align with white, Western conceptualizations of abnormal psychological behavior. This characterization of Latina women's behaviors worked to minimize their ED symptoms, since they were regarded as "normal" within

Latino culture. However, there was no specific discussion related to the nature of the relationship between Latino communities and food, which meant that the study's conclusions were incomplete in their ability to bridge together their claims related to psychological diagnoses and the influence of cultural norms.

Psychological research has begun to more effectively integrate aspects of cultural and racial diversity into the research process. However, these research studies continue to be based in previous work completed using populations of white women, which means findings are fixed in their comparative lens. Here, I hope to compare the experiences of black and Latina women with EDs to white women's experiences in order to demonstrate that new theoretical frameworks created outside white-dominated epistemologies must be utilized in order for women of color's experiences to be adequately represented and understood.

Chapter 2: Theory & Methods

Psychological knowledge is situated within a scientific framework which continues to largely ignore the collective experiences of people of color. Research studies have yet to comprehensively address the experiences and needs of ethnic and racial minority groups. Sociologist Donna Haraway explains that science is subjective, and calls for “a strong tool for deconstructing the truth claims of hostile science by showing the radical historical specificity, and so contestability, of every layer of the onion of scientific and technological constructions” (Haraway, 1988, p. 578). Haraway explains that science-based knowledge is biased and partial, failing to represent marginalized populations such as women since the majority of knowledge creators are white men. Therefore, Haraway argues “for politics and epistemologies of location, positioning, and situating, where partiality and not just universality is the condition of being heard to make rational knowledge claims” (Haraway, 1988, p.589). In the same way that Haraway shifted sociological knowledge to include the perspectives of women, I hope to create a new lens through which to understand EDs according to the perspectives of women of color. By taking a “view from the bodies” of women of color, described to me through the stories they have written, I will work to dismantle white-dominated narrative of EDs, and replace them with an inclusive, diverse, and intersectional feminist account (Haraway, 1988, p.589).

Dorothy Smith makes a similar epistemological argument related to how objectified forms of knowledge are created and expressed, as well as how these knowledges act as constituents of power in contemporary society. Although Smith’s argument works to question what the field of sociology would look like if it began from a woman’s standpoint, her framework will be used to help me question the dominant discourse present within ED-specific epistemology. Smith’s argument aids in questioning institutions “based on and built up within

the male social universe,” working to “alienate women from their own experience” (Smith, 1990, p.13). Smith concludes that “sociology for women would offer a knowledge of the social organization and determination of the properties and events of our directly experienced worlds” (Smith, 1990, p.11). A psychology for women of color with EDs, by extension, would provide a space for the body knowledges and collective identities of women of color to be integrated alongside rather than below white women’s experiences.

Haraway and Smith’s arguments, although gender-inclusive, lack a perspective on race. Patricia Hill Collins takes Haraway and Smith’s arguments regarding feminist epistemology and expands them to include a perspective which incorporates the impact of race on women’s identities and experiences. Collins agrees with Haraway and Smith, stating that “sociological traditions produced by a homogenous circle of insiders represent a partial perspective on social relations” (Collins, 1992, p.73). However, Collins expands upon Haraway and Smith’s arguments when she states that issues of race, class, and heterosexism, rather than just issues of gender, “present major challenges to the field [of sociology] as a whole” (Collins, 1992, p.73). Therefore, Collins’ perspective is especially helpful in questioning how race, class, and gender coexist within the bodies of women suffering from EDs.

Patricia Hill Collins reveals how black women’s ideas and actions have been pushed outside of traditional academic institutions of knowledge. Since their experiences have not been adequately represented, black women have been forced into an experience of dual, or bifurcated consciousness, becoming “familiar with the language and manners of the oppressor, even sometimes adopting them for some illusion of protection” (Collins, 1990, p.97). Collins’ work on *Black Feminist Thought* works to incorporate the “core themes of work, family, sexual politics, motherhood, and political activism to emphasize the importance of intersecting oppression in

shaping the U.S. matrix of domination” (Collins, 1990, p.251). In explaining *Black Feminist Thought*, Patricia Hill Collins discusses the importance of dialogues, and the fact that knowledge claims are usually developed “through dialogues with other members of a community” (Collins, 1990, p.260). Here, I enter into an ongoing conversation occurring within communities of women who are working to understand what it means to be a woman of color with an ED.

Over the past ten years many women of color and members of other marginalized groups have begun to tell their stories as a way to critique and shed light on their interactions with larger medical and psychological institutions. It is only in listening to these women and amplifying their voices that a more inclusive and truth-based story about EDs will emerge, allowing women of color to experience recognition and eventual healing. Therefore, published personal narratives about women's ED experiences served as the foundation of this thesis. Interviews with clinicians who specialize in the treatment of EDs were also utilized to illuminate the contrast between knowledge derived from women’s described experiences and dominant epistemological knowledge related to EDs. By treating women's stories as the primary source through which to understand EDs, this allowed women to define the truth of their own bodies outside the confines of traditional ED narratives and clinical diagnostic criteria.

Social media accounts and stories published online were used because these mediums serve as forms of knowledge that are not represented within institutions of medicine and psychology. It would have been extremely difficult to access a clinical population of diverse women for qualitative interviews, so I chose to pursue secondary data written or expressed by women online or in books. This method of data collection was effective for the collection of stories by black and Latina women, who have used social media and other forms of self-publication to share their experiences. Through the use of online communities, new knowledges

about race, ethnicity, bodies, and EDs have been created to challenge the dominant epistemological frameworks that currently serve as the foundation for what it means to be a woman with an ED.

Data Collection and Coding: Personal Narratives

Story data was collected from fifty-eight published stories and social media posts written by Latina, black, and white women between 2003 and 2017 about their experiences with EDs and/or disordered eating. Fifteen stories and posts were by Latina women, twenty stories were by black women, and twenty-three stories were written by white women. Table 1 (below) outlines where women's stories were acquired. See the Methodological Appendix for more detailed descriptions and links to women's stories and for additional information related to story authorship and story selection.

Table 1. Story Sources

<i>Publication type</i>	<i>Latina</i>	<i>Black</i>	<i>White</i>
Published memoir	1	3	1
Public blog	7	14	22
YouTube video	4	2	0
Podcast episode	2	0	0
Instagram page	1	1	0
<i>Total</i>	<i>15</i>	<i>20</i>	<i>23</i>

Women were grouped according to three racial/ethnic groups even though some women may belong to more than one of these groups. Latina women, for example, were selected based on their ethnic rather than racial identities, while white and black women were selected based on their racial identities. A summary table of information related to women's stories in the Methodological Appendix offers details related to race or ethnicity, such as country of origin, if

women included this information within their story. Women who identified as Latina were chosen based on whether they discussed living in the United States for an extended amount of time, since the impact of American culture on women's sense of embodiment and their relationship with food is a significant aspect of the study. Some Latina women may have grown up in Latin American countries but came to the United States for college, or moved to the United States at a young age. Some stories were written or spoken in Spanish; these were translated into English by the author, who is a native speaker of both English and Spanish.

Stories were found by searching public blogs and social media sites and assessing whether the content available fit the criteria of the study. See the Methodological Appendix for a list of search words used to accumulate stories. I first looked for published memoirs written by black, white, and Latina women about their experiences with EDs. Then, I gathered stories from public blogs and news outlets. Since I was unable to obtain enough stories by black and Latina women through blogs and memoirs to comprehensively compare the two groups to white women's stories, I looked for stories published on social media, YouTube, and podcast interviews. Although stories were diverse in how they were published, the stories included common elements that made the narratives similar across source types. These common elements included:

- A description of the onset of the woman's ED behaviors or issues with body image
- A characterization of the woman's childhood
- A discussion of or reference to the woman's family
- Descriptive language related to the woman's relationship to food
- The relationship between the woman's personal identity and her culture
- The impact of the media and body ideals on the woman's identity

- A discussion of how discrimination based on race, ethnicity, age, socioeconomic status, or body type affected the woman
- Descriptions of ED diagnosis and treatment
- A discussion of what it means to be recovered or a description of the tools women used to recover from their ED

Not all stories included every single element listed, however almost all stories included all or a majority of these elements. Memoirs and blog posts were more likely to cover all of these topics, which is why they were the preferred source of data. With one exception, all Latina and black women included discussions of race, ethnicity, and culture into their ED story while no white women discussed these topics. The three non-white women's stories who were published on the National Eating Disorders Association blog (Chani, Lakesha, Amber) were included in their "marginalized voices project," confirming the fact that other posts could be assumed to be written by white women. Therefore, white women's racial identities were verified based on the fact that their stories were not flagged as representing "marginalized voices" on the blog in which they were published. Stories varied in length, but were on average 1,000 words for blog posts, videos, and podcasts and 150-200 pages for memoirs. One black Instagram user wrote less than 300 words about her ED, however she embedded her story succinctly into a short narrative appropriate for the social media outlet that she utilized.

The first narratives that were collected within the sample included long-form stories written for blogs or memoirs written for publication. The memoirs used within the final sample include:

- *Hunger: A Memoir of (my) body* (2017) by Roxane Gay
- *How American Diet Culture Negatively Affects Latinas* (2016) by Vivana Rose

- *Through THICK and Thin and Thick Again: A Black Woman's Journey with BED (Binge Eating Disorder)* (2016) by Nettie Reeves Lewis
- *Not All Black Girls Know How to Eat: A Story of Bulimia* (2009) by Stephanie Covington Armstrong
- *Life Without Ed: How One Woman Declared Independence from her Eating Disorder and How You Can Too* (2003) by Jenni Schaefer

Very few Latina or black women have published their stories in books or on popular ED blogs which was why sources such as Instagram pages, YouTube channels, Tumblr sites, and Podcast interviews were used. Two podcast interviews were transcribed and analyzed alongside the written narratives. One podcast ([Food Psych Podcast Episode #103](#)) featured a white clinician interviewing a Latina woman in recovery from an ED, and the other podcast was narrated by a young Latina woman who described her experience with disordered eating and negative body image ([Saxelby Radio Scholars Episode 7](#)). The podcast interviews both focused on the Latina women's cultural identity, their upbringing and family, the onset of their ED/disordered eating, and the tools they used or are currently using to help them heal their relationship with food. Six YouTube videos uploaded by Latina and black women ([Diana](#), [Michelle](#), [Nicki](#), [Yovana](#), and [Chary Jay](#)) were also transcribed and included within data analysis. These videos featured the woman speaking directly to the camera (to her followers) about her experience with an ED. Two of the stories were cut up into three or more videos, where the woman told her story as it unfolded over time. These videos were considered as one continuous story.

Upon determining that a woman's story met the criteria for the study, basic demographic information regarding the woman's geographic location, their primary ED behavior(s), and

race/ethnicity was collected. Due to the tendency for women to not directly state the duration of their eating disordered behaviors, this data was not collected. Information related to women's age was also not collected, however women ranged from 17-74 years old, with most women falling into the 20-35-year-old bracket. I used a grounded theory approach to analyze women's stories which involved developing a coding schema according to the themes present within the data. I then compared those themes to insights from existing qualitative studies on EDs. In the initial "open" round of coding I noted when a woman's ED developed, why it developed, how and when women framed their racial and/or ethnic identity within their narrative, and the resources women used if they sought out care. After reading the stories I then refined the coding schema to include references to women's families, acculturation, trauma history, terminology used to refer to their EDs, how women described their experiences interacting with healthcare professionals, women's descriptions of their bodies, and references to religion, spirituality, loneliness, and recovery. The final coding schema included thirteen main themes:

- The woman's primary ED behavior or behaviors ¹ including over-exercise, purging, restricting, and bingeing.
- The events that triggered the ED or disordered eating.
- The impact that acculturation had on a woman's identity and her relationship with food.
- The role that the woman's family and community had in triggering the eating problems as well as helping the woman find healing.

¹ The decision to define women in terms of their primary ED behaviors was based on the fact that some women were never formally diagnosed with one of four major EDs defined in the *Diagnostic and Statistical Manual*. Women were instead classified in terms of the behaviors they described in their narratives rather than diagnoses they received. Behaviors include restriction, purging, bingeing, over-exercise, or engaging in other non-specified ED behaviors.

- Experiences of trauma that the woman faced, including sexual assault, rape, witnessing parent abuse, abandonment or non-present parents, emotional abuse within the family, bullying or teasing at school or work, other sickness or health issues, other major psychiatric issues or addiction problems, experiences of racism, or discrimination based on sexuality.
- The impact that Western media had on women's perceptions of their bodies as well as their relationship to food.
- How poverty impacted a woman's relationship to food and her body.
- Interactions that a woman had with healthcare professionals, particularly whether the interactions were positive or negative.
- A woman's access to general healthcare, including whether the woman was formally diagnosed with an ED, had insurance, or had access to outpatient or inpatient ED treatment.
- Descriptions of the woman's ED and the terminology women used to describe their ED.
- Whether a woman discussed feeling "not skinny enough" or "not looking like" she had an ED.
- Descriptions of loneliness, isolation, or having to fight or treat their EDs on their own.
- References to the role of religion and/or spirituality in the woman's life, especially as it relates to identity formation, embodiment, and healing.

Data Collection and Coding: Clinician Interviews

A total of fifteen interviews were conducted with clinicians who specialize in the treatment of EDs, including mental health counselors, clinical psychologists, school psychologists, clinical social workers, and one nutritionist. The majority of clinicians (60%) held Masters degrees in clinical social work or mental health counseling. Five clinicians had doctoral degrees in clinical, counseling, or school psychology. Clinicians worked in diverse settings,

including non-profit clinics, private practice, residential treatment centers, and hospitals. Eleven clinicians identified as white, three identified as black, and one identified as Latina. Thirteen clinicians identified as women; two as men. Clinicians had an average of 12.5 years of experience, with a range of 1-34 years. In the following chapters, clinicians will be referred to by general identifying characteristics such as their gender or race, or by referencing the order in which they were interviewed (e.g. “clinician #5”).

Clinicians were recruited to participate in the study predominantly through email. The contact information of clinicians was obtained through a public website built to help patients get connected with potential therapists, doctors, and nutritionists who specialize in treating various mental illnesses including EDs. Clinicians were also contacted by the programming director of a non-profit ED clinic with access to a network of local clinicians and through in-person networking at an ED conference.

Clinicians were invited to participate in an undergraduate thesis project investigating how issues of race and ethnicity play a role in the experience and treatment of EDs. They were told that their expertise as clinicians who treat EDs would add professional insight into the project. Clinicians were given the option to answer a series of ten to twelve questions via email, phone, or in-person interview (see the Methodological Appendix for interview schedule). Clinicians were encouraged to only answer the questions they felt they could answer based on their own experiences. Six clinicians were interviewed in-person, two interviews were conducted on the phone, and the remaining seven clinicians responded to the questions and emailed their responses. In-person interviews were recorded and transcribed with the verbal consent of the clinician.

Interviews were coded to assess the extent to which clinicians incorporate issues of diversity and multiculturalism into their practice. An initial set questions were prepared to obtain specific information from clinicians, however in-person and phone interviews were conversational, and additional questions and topics arose during some interviews. The following information was coded for within each interview:

- Client Population Type – Does the clinician have experience with or currently work with minority clients?
- Perception of ED Demographics – Does the clinician believe that common characteristics are shared amongst all individuals with a diagnosis of an ED?
- Training – Does the clinician feel as though they received proper training in issues of multiculturalism and diversity as it relates to the experience and treatment of psychological disorders?
- Social and Cultural Factors – What social and cultural factors does the clinician think are most salient in the development of an ED?
- Race and Ethnicity Within the Practice – Does the clinician feel like it is necessary to incorporate issues of race into their practice?
- Perceptions of the Impact of Race/Ethnicity – How does the clinician think race impacts the experience and treatment of someone's ED?
- Accommodations – Does the clinician's practice accommodate individuals who seek out their care? This includes accommodations such as accessibility by public transit, taking many types of insurance, offering scholarships, sliding scale prices, or being available after work hours.
- Clinician's Personal Identity- Clinicians were given the opportunity to discuss how their

personal identity interacted with their role as a therapist throughout the interview or while answering the questions. Two questions² related to personal identity were added in the final three interviews conducted.

Bringing Together Personal Narratives and Clinician Interviews

Data collected through women's personal narratives were combined with clinician interview data to investigate why some women are more likely to be diagnosed and receive treatment for their ED by psychological and medical professionals. Chapter 3 considers the way that EDs are defined according to psychology's *Diagnostic and Statistical Manual*, comparing those criteria to women's descriptions of their EDs. Clinician interview data was then assessed for the degree to which clinician's perspectives on EDs aligned with traditional diagnostic criteria. Chapter 4 defines how women described their EDs and their identities in comparison to how clinicians described EDs in order to discern how traditional psychological and medical epistemologies were integrated into women and clinician's understanding of the experience of EDs. In chapter 5 women's critiques of ED treatment were considered in light of the types of accommodations clinicians offer clients to determine how clinicians can better cater to the needs of racially and ethnically diverse populations of women.

² (1) How many mentors or professors of color were you able to interact with in graduate school, or even during your undergraduate studies? How did those relationships impact your learning?
(2) How have aspects of your personal identity impacted your practice?

Chapter 3: The DSM and Diagnosis

Receiving an ED diagnosis is an imperative first step in receiving professional help. The National Eating Disorders Association (NEDA) states that early detection and evaluation “are important steps that can help an eating disorder sufferer move into recovery more quickly, preventing the disorder from progressing to a more severe or chronic state” (NEDA, 2016). According to women’s stories, however, not all women with ED behaviors were diagnosed. This chapter will explore some of the reasons why black and Latina women were less likely to receive an ED diagnosis, focusing specifically on the language of the DSM and clinician training.

Of the women that Becky Thompson interviewed for her book, *A Hunger So Wide and So Deep*, “only two had been diagnosed bulimic or anorexic by physicians, yet all who said they were anorexic or bulimic fit the diagnostic criteria (DSM-III) for these diagnoses” (Thompson, 1994, p.13). Dr. Thompson explains that “the association of eating problems with ‘whiteness’ has made some women of color unwilling to seek help. Getting help may feel like ‘selling out’ or being treated as an oddity by friends or medical professionals” (Thompson, 1994, p.15). The same pattern was present within the data I collected on white, black, and Latina women who told their ED stories. Although each woman’s story included details of her ED behaviors (Table 2), not all women were officially diagnosed with an ED by a clinician even though almost all women described interacting with a healthcare professional within their stories. Even when black and Latina women “sold out” and sought out professional help, they were not always given the care they needed. In fact, only 50% of (10/20) black women and 66% of (10/15) Latina women were officially diagnosed with an ED, in comparison to 96% of (22/23) white women. Black women were least likely to get diagnosed with an ED, even though they also described engaging in eating disordered behaviors such as restricting food, binge eating, and purging. And since

receiving a diagnosis is the first step necessary to receiving treatment for an ED this means that black women were the least likely to receive help.

Table 2. Women’s ED Behaviors

	<i>Black</i>	<i>Latina</i>	<i>White</i>
Restriction	30%	27%	40%
Restriction, Binge Eating	5%	13%	0
Restriction, Bingeing, Purging	10%	27%	9%
Binge Eating	25%	0	4%
Restriction, Purging	20%	20%	24%
Binge Eating, Purging	5%	6%	12%
Unspecified ED behaviors	5%	6%	8%

The DSM and EDs

The DSM criteria for EDs did not align with how black and Latina women described their experiences with EDs, which may have contributed to the fact that white women in this sample were significantly more likely to be officially diagnosed with an ED when compared to Latina or black women. EDs, as they are defined in the DSM, can be summarized in terms of three characteristics which associate them with whiteness: (1) EDs are rigidly associated with white Western culture and are a response to desires to approximate the ideals of the Western environment. (2) EDs always occur in slim, young bodies which are achieved in order to approximate Western body ideals. (3) Women with EDs (specifically anorexia and bulimia) use their behaviors primarily to become skinny within the context of the Western fat-phobic society. I will first turn to evaluating the specific terminology used to define EDs within the DSM in order to explain the persistence of rigid stereotypes related to who suffers from EDs.

Anorexia Nervosa. Anorexia nervosa is defined in the DSM as commonly beginning during “adolescence or young adulthood” in “cultures and settings in which thinness is valued,” and can be triggered by a “stressful life event such as leaving home for college.” Warning signs for anorexia as include symptoms such as significant weight loss, distorted body image, intense fear of gaining weight, pale appearance/yellowish skin tone, thin or dulling hair and skin, fatigue, and compulsive exercise. The DSM-5 defines three main criteria for anorexia nervosa, including caloric restriction leading to low body weight, an "intense fear of gaining weight or becoming fat" even if they are underweight, and an inability to recognize the "seriousness of the current low body weight." The DSM specifies that the criteria for anorexia nervosa "requires that the individual's body weight be significantly low," and that "body mass index is a useful measure to assess body weight for height” (APA, 2013, p. 340-342).

Bulimia Nervosa. Bulimia is characterized by binge eating and compensatory behaviors such as purging or over-exercise. Warning signs for bulimia as stated in the DSM-5 include secretive eating, visiting the bathroom after meals, preoccupation with food, weight fluctuations, abusive of laxatives or diet pills, and physical symptoms such as sore throat, heartburn, and discoloration and/or staining of the teeth. Bulimia is defined as being “uncommon among obese individuals” and linked to the “internalization of a thin body ideal.” The DSM also states that “clinical studies of bulimia nervosa in the U.S.” have shown that “individuals presenting with [bulimia] are primarily white” (APA, 2013, p.358).

Binge Eating Disorder. According to the DSM-5, binge eating disorder (BED) is the most common ED in the United States. Individuals with BED engage in frequent bingeing episodes which usually occur over a short period of time. These bingeing episodes are likely to occur when an individual is alone or depressed, are "marked by feelings of lack of control," and lead to

further feelings of distress. Binge-eating episodes occur when an individual eats large amounts of food much quicker than they usually do, eating beyond the point of satiation. BED is cited as occurring in “roughly similar frequencies in most industrialized countries,” as well as across racial and ethnic groups in the United States (APA, 2013, p. 350-352).

OSFED. “Feeding or Eating Disorders Not Otherwise Specified” (OSFED) diagnoses include atypical anorexia nervosa, bulimia nervosa (of low frequency and/or limited duration), binge eating disorder (of low frequency and/or limited duration), purging disorder, or night eating syndrome. Atypical anorexia nervosa is defined as occurring in individuals who “fit all the criteria for anorexia nervosa,” but are of normal or above normal weight. Both bulimia nervosa and binge eating disorder of low frequency and/or limited duration are diagnoses given when someone is not engaging in the ED behaviors frequently enough to warrant a traditional diagnosis. Purging disorder occurs if when someone has “recurring” purging episodes without engaging in food binges. Night eating is defined as occurring when an individual consumes large amounts of food after the evening meal, which is not linked to the use of substances (APA, 2013, p. 353-354).

A “Typical” ED Narrative

The ED narratives told by white women aligned with the DSM’s diagnostic criteria for EDs, and framed EDs in reference to thinness, youth, and Western body ideals. White women’s stories were most likely to center around achieving thinness, as Jenni Schaefer admits in her book when she states that she “definitely did not think that [she] was thin enough to have an eating disorder,” even though she describes engaging in rigid food restriction and over-exercise (Schaefer, 2003, p.23). Sue, who was diagnosed with bulimia, also described her ED experience as rooted in slimness. She described that “although I was losing weight, the desire to be thinner

and thinner never ended. No matter what my weight, it was never thin enough - and preventing weight gain was exhausting. Not much else mattered.” Colleen also stated in her story that “I believed that eating disorders were about appearances and how important thinness was.” Jenny, Sue, and Colleen all determined how sick they were based on their body size, which aligns with the DSM’s focus on BMI and physical signs of illness as primary indicators of an ED.

The ED recovery stories featured on The National Eating Disorders Association (NEDA) blog are similar to Sue and Jenni’s stories, since most of the stories are written by white women who have had similar ED experiences. I say this not to minimize the individual experiences of suffering that each of these women had, but to point out how easy it is to be flooded with a singular story, making it seem as though that story represents all EDs. The story inevitably goes something like this – a young girl develops an ED when she is a teenager which leads her to get very physically ill. She is then put into ED treatment by her family and works hard to fight her ED, which leads her to eventually achieve full recovery. There is usually a disclaimer at the end of the story emphasizing how difficult recovery is. For example, Christina F. describes her story in a NEDA blog post, which includes references to thin body ideals, diet culture, and eventual self-acceptance:

"I spent my teens dieting and exercising my way to a thinner body that never appeared. In my twenties I hid out in an ever-expanding body that simultaneously protected me from hurt and hurt me with ill health. And I found recovery in my thirties and learned to accept what at first seemed like a hard truth: my body size has limits that cannot be dictated by me or any expectations set forth on the covers of a thousand magazines."

Christina’s story also emphasizes the contradictory role of the ED as both a protector and a destroyer. In general, white women turned to their EDs to protect them from the body-based trauma that they encountered such as bullying, sexual assault, or low self-confidence due to comments from family, social comparison, and the media’s perpetuation of a thin body ideal.

However, their EDs ultimately betrayed them by destroying their bodies rather than protecting them. The promise of protection that EDs provided began when many white women were at extremely impressionable times of their lives. Sheryle, Kate, Jackie, Christina, Kim, Lindsay, and Rachel all described developing EDs when they were young. Lindsay remembers the exact moment she realized she was “fat” when she was in 3rd grade. As a way to deal with the misogyny that was projected onto them from a very young age, women turned to EDs. Kim explains that, “looking back, my eating disorder had several voices. It was saying: ‘I am angry. I am afraid. I want to disappear. I give you a sense of control and accomplishment.’” EDs provided women with a sense of control over their bodies that they had never had access to due to the misogynistic beauty standards that surrounded them.

American society’s obsession with weight and weight loss was apparent in white women’s stories. EDs served as a way for white women to align themselves with Western body ideals, which they felt their bodies were being directly compared to. White women’s stories emphasized the fact that “there are reasons why this is happening, and they do not lie in the mind alone” (Hornbacher, 1998, p.5). Marya Hornbacher’s influential 1998 ED memoir *Wasted* includes a discussion of the impact that society and media have the development of EDs. She writes that:

“There were numerous methods of self-destruction available to me, millions of ways in which I could have responded to a culture that I found highly problematic. I did not choose those ways. I chose an eating disorder. I cannot help but think that, had I lived in a culture where ‘thinness’ was not regarded as a strange state of grace, I might have sought out another means of attaining that grace” (1998, p.6-7).

White women’s stories within this sample reflected a similar relationship between culture, media, and EDs. Jackie explained in her story that, “I was absolutely fascinated with weight loss commercials. When one came on the TV, I would stop what I was doing, listen to

them, and dream of growing up and buying anything and everything that was out there, to keep my weight down.” The DSM emphasizes a link between EDs and “industrialized countries” like the United States, where a thin body ideal is perpetuated through culture, media, and capitalism. White women linked the development of their ED with the internalization of thin body ideals and the relationship that female body ideals have to misogyny. This relationship is also reflected in the DSM, and serves as the environmentally-based explanation for EDs. This alignment may have made white women more likely to receive an ED diagnosis. Almost all of the white women were also able to access general healthcare (96%). This access, alongside the more rigid conformity to diagnostic criteria, contributed to the fact that white women were more likely to be diagnosed with an ED.

Presenting a New Narrative

Black and Latina women’s ED narratives defied the pervasive white-washed story of EDs. Instead of fitting into the characteristics that defined the prototypically white ED, Latina and black women told a different story. To say that EDs don’t discriminate based on race or ethnicity dismisses the lived experiences of individuals whose lives have been shaped by the color of their skin, or the ethnic group they belong to. Claiming that EDs are all the same, no matter what bodies they reside in, denies the fact that Latina and black women’s EDs serve as a way to help them cope with the marginalization and oppression that they experience as women, people of color, or members of non-American cultures. The oppression that they described pushed them to develop an ED as a way to “[deal] with systems of power” and social inequality (Fabello, 2018).

Nettie Reeves Lewis describes in her memoir *Through THICK and Thin and Thick Again: A Black Woman’s Journey with BED (Binge-Eating Disorder)* that “if you think back to

our African American history, food was a hot commodity. As slaves, we were certainly punished or rewarded with meals for getting work done or not. Obeying the master was absolutely the factor in whether or not you were going to eat. Momma raised me with that mindset. It was the only way she knew” (Reeves-Lewis, 2016). Nettie outlines the life experiences that led to her struggles with BED, highlighting especially how being a black woman impacted the onset of her behaviors. Nettie was able to receive treatment for her ED, and her story is a reminder of just how important diagnosis is, especially since many women of color struggle with recognizing that they are deserving of care. Nettie even describes feeling suspicious about whether she was deserving of care in the midst of receiving help: "something is really wrong with me. I think I have an eating disorder. But I don't have anorexia – there is no problem with me eating. And I don't have bulimia- I binge but I certainly don't purge. So I probably don't have an eating disorder." Nettie’s ED behaviors fell under the diagnostic criteria of binge eating disorder. The symptoms of binge eating occupy the other end of the spectrum from anorexia nervosa. In the sample of stories I have included in this analysis, black women had the highest percentage of bingeing behaviors (25%). These ED behaviors are more likely to be medically classified as an obesity problem, rather than an ED. Thus, binge eating may be harder to diagnose, and harder to treat due to the idea that at the root of an ED is a desire for slimness.

Roxane Gay, author of *Hunger: A Memoir of (my) Body*, described struggling to recognize that she had a problem, as evidenced through her inability to use the word bulimia to describe her bulimic behaviors, stating that “it always feels strange to use the word with regard to myself” (Gay, 2017 p. 194). This is largely because EDs are associated with slim, young bodies – bodies which want to become smaller, rather than bodies that take up space, even if they are empty. Gay also felt like she was too old to have an ED, which Nettie also noted in her

memoir. As a fat woman in her forties, Gay did not fit the criteria that the DSM outlines and the media perpetuates. The DSM notes that bulimia occurs but is "uncommon among obese individuals." Similar to anorexia, bulimia nervosa is said to be triggered by the "internalization of a thin body ideal" which increases a person's risk for "developing weight concerns" (APA, 2013, p.358). The DSM directly links bulimia to a drive for thinness, making weight bias more likely.

Diagnostic Criteria, Body Size, and BMI

One of the themes that consistently arose within black and Latina women's stories was the presence of weight bias, or the fact that women of color felt like their bodies did not look eating disordered enough. Many non-white women explained that even though they were restricting or purging, they were not skinny enough or sick enough to be deemed clinically "eating disordered." Their body mass index (BMI) was too high, according the ED diagnostic criteria. Body mass index is a commonly used medical screening tool, taken from dividing weight in kilograms by height in meters squared (Harvard Obesity Prevention Source, 2017). A person who is of "healthy" weight is defined to have a BMI between 18.5 and 24.9. Anyone beyond 25 is classified as overweight, and anyone over 30 is "obese." The categories go on to classify "obese" individuals further as their ratios increase, all the way up to "super-super obese." (Harvard Obesity Prevention Source, 2017). Within the context of EDs, the DSM-5 states that a person with a BMI equal to or lower than 18.5 should be considered underweight, which may be a warning sign for a restrictive-type ED (APA 2013, p. 340).

The use of BMI as a measure of overall health is flawed and has caused many women with and without EDs to feel inadequate. The World Health Organization acknowledges that there is a need to develop "different BMI cut-off points for different ethnic groups due to the

increasing evidence that the associations between BMI, percentage of body fat, and body fat distribution differ across populations" (WHO, 2006). None of these traits are taken into account when calculating BMI. However, this does not eliminate the amount of power given to BMI in judging a person's health status. According to the Centers for Disease Control and Prevention (CDC), body weight accounts for only about a quarter of the differences that are seen in people's health outcomes (CDC, 2014). The majority of a person's health status is determined by what the CDC refers to as "social determinants of health," which are grouped into the three categories of "social environment, physical environment/total ecology, and health services/medical care"(CDC, 2014). The CDC explains that "addressing social determinants of health is a primary approach to achieving health equity," which can be defined as the opportunity for everyone to "attain their full health potential" (CDC, 2014). A person's baseline health status, therefore, has more to do with the social environment they are in rather than their weight.

The fact that a person's health is only partially determined by their weight becomes especially important when considering that the DSM-5 contains BMI-specific criteria for diagnosing EDs. The use of BMI equates a person's body weight with how sick they are. However, a person with an ED who would be classified as "overweight" according to a BMI chart is no less sick than someone who is classified as underweight when considering a person's mental health status. Although EDs are understood as a mental illness, they are diagnosed according to physical criteria and therefore become vulnerable to fat-phobia. Whether or not someone is presenting with an ED, doctors should focus more on the social determinants of health if they hope to really contribute to achieving health equity. This includes an awareness of the factors outside of the body that have a direct impact on the body, such as "social position, education, occupation, income, gender, and ethnicity/race" (CDC, 2014).

Roxane Gay makes her opinions on the BMI clear – “the measure for Body Mass Index (BMI) is so fucking arbitrary. They decided on 25 because it's a nice, round number. A bunch of generally white men are in a room somewhere making decisions about millions of people” (Etter, 2017). In completing her book, Gay describes that she “did a lot of research about bodies, fat, and fatness” in order to inform her discussion of her own body, as well as how bodies are understood in today’s body-obsessed culture (Etter, 2017). Gay writes extensively in her book about the distrust she has for doctors. And those doctors deserve her distrust, because according to them and how they have treated her, Gay’s health can be assessed by nothing more than her weight.

Being fat did not protect Gay from developing an ED. However, when Gay describes her ED in her memoir *Hunger*, she has trouble admitting to herself that she is sick:

“I have chronic heartburn because I used to make myself throw up after I ate. There’s a word for this, ‘bulimia,’ but it always feels strange to use the word with regard to myself. For a time, I did try to become that girl I envy, the one with the discipline to disorder her eating. I didn’t do it for that long, I tell myself. That’s not really the truth, I did it for about two years, which isn’t that long but is enough. Or maybe I don’t want to use the word because it was so long ago, which is absolutely not the truth. (Gay, 2017, p. 194)

As a fat black woman Gay learned not to put her trust in medicine when it came to taking care of her body. And the idea of trust quickly emerged as a theme in other black and Latina women’s stories. Non-white women learned to not trust that others would see their experiences as eating disordered, even though they were engaging in ED behaviors. A refrain that came up again and again, especially within black women’s stories, was something along the lines of “we get EDs too.” Women of color worked this idea into their stories somewhere in order to make their readers aware of the fact that they knew they don’t fit the mold. It was as if even before they were able to tell their stories, these women had to anticipate the criticism that would entirely discredit their experience. They needed to say it out loud – black girls get EDs too:

“I’d be lying if I said the thought, *Black people don't have eating disorders* didn't cross my mind. It did. But EDs don't discriminate, and navigating the world as a bulimic African-American woman is tough. We're portrayed as strong women — women who believe black is beautiful, and filled with pride of our ancestral curves. We're supposed to appear confident and have it pulled together. In my experience, this was true in every area of my life — except when it came to my body.” (Shanetta, black).

Although many non-white women recognized that their relationship to food was unhealthy, the suffering of their bodies were often not acknowledged by clinicians. Patricia Hill Collins discusses how black women’s body knowledges are undermined in *Black Feminist Thought*. Collins explains that epistemology should “[investigate] the standards used to assess knowledge or why we believe what we believe to be true.” She goes on to tell the story of Sally Hemmings, “a black woman owned by Thomas Jefferson,” who repeatedly “claimed that that Jefferson fathered her children. These accounts forwarded by Jefferson’s African-American descendants were ignored in favor of accounts advanced by his white progeny. Hemmings’s descendants were routinely disbelieved until their knowledge claims were validated by DNA testing” (Collins, 1990, p.252). Until the black descendants of Thomas Jefferson were able to provide scientific proof of their ancestry, they were not taken seriously. Until they were able to use the tools provided to them by scientists, their experience was not legitimized. The story provides us with an example of how black women must prove the truth of their bodies and their trauma in light of dominant, white epistemological frameworks in order to receive any sort of recognition or assistance.

One Instagram user, who identified as Hispanic, described on her Instagram page that although she is “188 lbs” and “still restrict[s] and purge[s] to the point where I faint,” she still was subjected to comments such as “you aren't sick enough” which she said “just makes things worse.” This young woman described that “I know I'm not the stereotypical eating disorder looking girl but I am still suffering.” Like Nettie and Roxane, who both struggled with their

weight throughout their lives, the Instagram user felt like she was not skinny enough to be suffering from an ED. Although the Instagram user described using behaviors such as restriction and purging, which are commonly associated with slimmer bodies, her body does not conform to the BMI cutoffs outlined in the DSM for anorexia or bulimia. The Instagram user's experience is also similar to Viviana's, whose anorexia nervosa was deemed as "atypical" because her body was too big. Latina women are in fact most likely to receive a DSM diagnosis of OSFED (Konstantinovsky, 2014). These women's bodies have been classified as too big, and therefore fall outside the realm of traditional restrictive ED diagnoses such as anorexia and bulimia.

Danielle, a black woman, also realized how her body does not conform to the stereotype of the eating disordered body. She writes that:

"[eating disorders] seemed like something that was only ailing the white girls in my class, who were often chatting amongst themselves about how fat they were, when they were literally half my size. Never mind the fact that in that very class, there were two snack-size Snicker bars in my bag that I couldn't wait to sneak a bite of. I wasn't the one with the problem."

Danielle's description of understanding her ED in reference to the "white girls" in her class who struggled with fat-phobia is what convinced her that she did not have a problem. This belief came from the idea that EDs are only present in small bodies, which assumes that women with EDs are fat-phobic, obsessed with their self-image, and are using their ED behaviors only to get skinny. However, women suffer from eating disorders for reasons beyond aesthetics, and are very likely to be coping with experiences of trauma through their ED.

The black and Latina women who shared their stories felt forced to frame their experiences around food and their bodies in terms of a singular narrative, which ultimately left them feeling unseen and unheard. When they were able to own their own stories, their experiences with EDs challenged the narratives outlined by white women. Their stories were about their trauma, disorganization, numbness, family, racism, and confusion. More strikingly,

though, their stories are about coping with being simultaneously visible and invisible. The color of their skin made women visible and vulnerable to stereotypes, racism, and bias. However, Latina and black women with EDs became invisible when they experienced EDs because they were not white. Nicole, a black woman who described both behaviors of restriction and purging in her story, recounts one of the first times her ED was dismissed by a white friend:

"One day I went to the movies with [a white friend] and she asked me once again what I have eaten that day. When I answered truthfully again with some subconscious hope of being stopped she said something that will always stay with me. 'Black girls don't have eating disorders...?' Everything about it was dismissive. It was the first time someone finally labeled my actions what they were – an ED. But in the same breath, these words were denying my hurt because of the color of my skin."

Nicole's blackness disqualified her from having the same disorder that her white friend was capable of having. The dismissal of her suffering was due to her inability to fully approximate whiteness, as her friend defined it. As Stephanie describes in *Not All Black Girls Know How to Eat*, "because I was a black girl with natural hair who had grown up below the poverty line, no one ever suspected I could be bulimic. My color became the perfect shield against suspicion" (Covington Armstrong, 2009, p.149). Stephanie's blackness, and the stereotypes that being black brought with it, made her ED invisible. Because Stephanie did not live in a larger body, her size did not necessarily render as invisible as her skin did. However, for women like Roxane, Instagram user, Nettie, and Gloria, their skin color and body size meant that they were ineligible to fully claim an ED diagnosis as their own.

EDs and American Culture

The idea that EDs are an "American" disease situated within Western culture made it especially difficult for Latina women to get their disorder acknowledged and receive a diagnosis. Carmen tells the story of her battle with anorexia nervosa and the difficulties she had getting diagnosed as a first-generation Cuban-American. Carmen's parents had never seen or heard of

anorexia nervosa, and it took a family member's insistence to finally get her parents to recognize what they saw as an "American disease." Carmen describes that, "I am living proof that anorexia is not just an 'American' disease. It can happen in any family." Doctors considered that Carmen may have even been suffering from cancer before realizing that she had anorexia nervosa. It took months for her to receive her diagnosis, and by that time, she had already lost a dangerous amount of weight. Carmen was privileged enough to have access to medical care, and was carted around by her parents for second and third opinions. However, it was her Cuban identity that was the main roadblock to receiving her diagnosis. Her parents had not considered or even heard of the disease because their culture did not have the words to articulate the ED experience. Her ED defied the idea that EDs only occur within a Western context, and as a direct result of wanting to approximate white beauty ideals.

The fact that many black and Latina women described struggling to receive an ED diagnosis led to heightened feelings of isolation within black and Latina women. Ninety-five percent of black women described feeling lonely or isolated in their stories, alongside 80% of Latina women, and 56% of white women. In order to better understand why many women aren't receiving diagnoses, even when they have the opportunity to interact with a psychologist or doctor, I will explore the conversations I had with clinicians who specialize in the treatment of EDs. Their perspectives elucidate why women of color especially experience roadblocks in receiving a diagnosis.

Expert Perspectives

As scientists, doctors and therapists are trained to think in terms of numbers, diagnoses, and treatment outcomes. It is an efficient and objective way to be trained, especially when your job is to heal sick bodies. However, this approach falls short when considering the link between the

body, the mind, and the social world. The relationship between EDs and the social world is currently understood in terms of white body ideals and cultural norms related to how white women must look and act. This conceptualization of EDs is reflected in how the DSM has defined EDs, and how clinicians understand them. I interviewed clinicians because I wanted to understand how they understand the relationship between race, ethnicity, and EDs since the topic is not consistently reflected within psychological epistemology. From the interviews I conducted, I was able to conclude that there are at least three reasons why many clinicians who treat EDs are not currently equipped to understand and address the needs and experiences of black and Latina women: (1) Many clinicians who specialize in treating EDs (who are predominantly white) do not have exposure to working with diverse populations, and primarily work with populations that look like them and may have similar backgrounds to them. (2) The "diversity" or "multicultural" training that clinicians received in graduate school was not multidisciplinary, and in some cases was non-existent. (3) EDs are understood as presenting similarly in all bodies, therefore clinicians may be impacted by the stereotypes they unconsciously hold about eating disordered bodies.

Nine of the fifteen clinicians I interviewed felt as though they received adequate multicultural training during graduate school or within a clinical training setting. When I asked clinicians to recall the training they received related to multiculturalism and race, some were able to express that they were satisfied with the training that they received. However, I received more answers such as "sadly, I wouldn't say multicultural issues are a big focus of mine," or "I didn't do any sort of specific multicultural training, but eating disorders are more common among white females" (Clinician #4, Clinician #5). Other clinicians who did not receive multicultural training in school described learning about multicultural issues after attending school, in places such as

"conferences that focus on EDs" (Clinician #2). Other clinicians described having to simply navigate educating themselves on issues related to culture, race, class, and EDs. For example, one clinician described "I've had minimal formal training or seminar experience in multicultural issues around eating disorders. I try to learn about the person's unique experiences individually and in family to understand how the eating problems are related" (Clinician #6). Clinicians who had been working in the field for many decades noted that their formal education did not include issues of multiculturalism or diversity. Some of the younger clinicians discussed how the programs they attended focused on multicultural issues more heavily. However, as one of these clinicians explained, "my program focused on diversity heavily but they still could do better. My peers were almost entirely white. We did have a specific [multicultural] course that was required, you couldn't get your Masters without it. Unfortunately, the course that I took wasn't new information to me" (Clinician #8).

Being trained in "multicultural" or "diversity" issues is important, considering the fact that psychology as it is currently taught is predominantly the psychology of white people. When learning about clinical psychology, it can be assumed that the populations being referenced have been researched in predominantly white subject pools. It is only when learning about issues of "diversity" that clinicians are reminded that not every experience is the same. It took talking to a clinician of color who specializes in the treatment of EDs for me to truly realize how important it is for diversity to become integrated into training, especially ED training:

"A lot of my internships did emphasize multiculturalism and social justice. However, there was nothing for eating disorders. When I did finally get my last two placements for EDs, there wasn't much of a multicultural component. In fact, I was asked to be more the educator on that end, and then when I was in one my residencies that was really multicultural I was asked to be more the educator on the eating disorder. It was always trying to flip those roles" (Clinician #11).

As a clinical psychologist and a person of color this therapist holds two conflicting roles. She is the expert of two anomalous experiences. As a Doctor of Psychology who specializes in treating EDs, she is able to provide an expert perspective. As a person of color, she is also able to provide another perspective that does not often get represented in many clinical or academic settings. This clinician discusses being turned into the educator on the relationship between diversity and EDs, solely due to her identity as a person of color. What does this tell us about the expertise that white clinicians possess regarding the issues that their non-white clients experience? It is not necessary for a psychologist to be a person of color to really understand the experiences of people of color with EDs, however currently it seems like clinicians of color are the only ones with this sort of expertise.

Of the eleven white clinicians I interviewed, only one clinician told me they had worked with many clients who identify as a racial or ethnic minority for a consistent amount of time. Most white clinicians who treat EDs predominantly treat white clients. When I asked clinicians about their client populations, they were described as simply "white," "mainly Caucasian," or "white, of middle or high SES" (Clinicians 1,2,5,6,7,8, 9,14, and 15). This makes it extremely difficult for clinicians to get comfortable challenging the whitewashed stereotype of EDs that they are taught in school and by the media. As one white clinician describes:

"The lack of diversity within my clients drives me absolutely insane. I used to work with much more diverse populations, but since I fell into working with EDs, I fell into a population of people that, although there is a tremendous diversity in those who suffer, the people who are more diverse are not getting services, there's no question about it" (Clinician #9).

This clinician recognized the discrepancy between the homogeneity of her client population and the diverse group of people she knows suffer from EDs. However, she claims there is not much she can do about it, as a white clinician who works in a wealthy, white suburban area. The clients that she sees look like her, and have experienced a life similar to hers when it comes to

experiences of socioeconomic, family, culture, and race. It is a comfortable space to be in, both for her and for her clients. But this comfort means that the status quo is not being challenged, and those more "diverse" people who are suffering are not being treated.

When I asked clinicians about whether there was truth to the idea of a typical ED sufferer, or whether they thought there were common driving factors behind the development of an ED, clinicians seemed to agree that there is no such thing as a typical sufferer. However, there was discussion of similarities in personality and presentation, with ED patients being more likely to have a "need for control" and experience "body dysmorphia" or "body hatred" (Clinicians #4,5,6,7,8,9,10,12,). Thus, clinicians described being able to anticipate the kind of person who would be likely to show up in their office. This hypothetical client, according to most clinicians, was likely to desire control over their life, have negative body image, be impacted by the messages they received from their family and the media. Most clinicians did *not* expect a typical client to experience the types of trauma, racism, and social marginalization described in the stories by black and Latina women with EDs. Only one white clinician brought up the relationship between EDs and racism, oppression, and social oppression, while five clinicians of color discussed this relationship. This emphasizes the important role that personal racial and/or ethnic identity plays in a clinician's understanding of EDs. Most white clinicians currently do not have an ability to integrate an understanding of how black and Latina women experience EDs since these experiences are not integrated into pedagogy, and not present in their everyday lives.

Diversity and Exposure

Although the DSM acknowledges the relevance of environment and culture when it comes to anorexia nervosa, stating that an "association with cultures and settings in which thinness is valued" is supported, the extent to which environment and culture are integrated into diagnosis

and treatment is limited (APA, 2013 p. 342). Since the DSM also states that anorexia nervosa is "probably most prevalent in post-industrialized, high income countries such as the U.S. but it's incidence in most low-and middle-income countries is uncertain," this also confirms the fact that EDs, and specifically restrictive EDs such as anorexia nervosa, are conceptualized as existing in Western, white contexts (APA, 2013 p. 342). These claims are rooted in scientific psychological research, which quantifies how EDs differentially affect bodies based on race or ethnicity. However, these studies represent how psychological research continues to be a top-down process, grounded in the traditional knowledge of psychology, which is overwhelmingly white-washed.

The way that EDs are understood, both by the public and by clinicians themselves, is rigid. The clinicians who create and disseminate knowledge do not have many opportunities to challenge the rigid stereotypes that they are being taught, whether that is in their formal academic training or their within their professional practice. They don't have enough exposure to working with people of color. The word "exposure" is poignant, especially when considering the fact that it was the term I used to ask clinicians about their experiences with people of color. An exposure to something denotes a level of newness and discomfort that seems to describe what it is like for many white people to interact with and challenge their stereotypes about people of color, or people who are not culturally American. Because most of the clinicians I interviewed were white, and work in predominantly white communities, "exposure" is the right word to use. Clinicians needed to be "exposed to" a world other than their own in order to begin to understand it. Since 77% of the people receiving masters or doctoral level degrees in psychology are white, while only 5% are black/African-American and 5% are Hispanic/Latino, multicultural psychology is most likely to be an experience of exposure (APA, 2002). Experiencing the world

in a white body affords individuals the privilege to be unaware of the extent to which living in a black or brown body is traumatic. Until more people of color begin to practice the discipline of psychology, white perspectives will continue to dominate, rendering people of color's experience as the "Other."

When asked about his training on multiculturalism and diversity in earning his degree in counseling psychology, a black male clinician articulated that:

"As field, I would argue that psychology (and allied professions) have more work to do to increase awareness, culturally sensitive and responsive care, and general inclusivity. Psychology, in particular, is still viewed as a resource for white, upper middle-class women. There continue to be systemic barriers to access. Efforts to increase equity and equality in the field are strongly needed" (Clinician #15).

This clinician points to three important conclusions that I also came to through reading black and Latina women's stories and speaking to clinicians: (1) Psychology as a discipline and academic institution must work to integrate multiculturalism and diversity more consistently into diagnostic criteria and pedagogy. (2) The clinical resources made available by psychology professionals must take into account issues related to culture, family, immigration, language, race, ethnicity, power, and anti-fat bias. (3) Clinicians must be able to take these issues into account when diagnosing their patients because currently many people of color are misdiagnosed, or not diagnosed at all.

I don't have a magic solution to these problems. But as an undergraduate intern at the Multi-Service Eating Disorders Association (MEDA) in Newton, MA, I learned about how a community organization can work to adapt diagnostic criteria to their client population. By placing the words and experiences of their clients EDs at the forefront of their practice rather than relying on strictly on diagnostic criteria, MEDA has been working to re-define how EDs are

defined and diagnosed. Instead of focusing on diagnoses, the organization sees all EDs as representative of the same underlying issue.

MEDA serves a homogenous population of predominantly white women. The physical space is located in a wealthy suburban town inaccessible by public transit, which means that although the organization provides low-cost ED resources to the community, these resources are only accessible to some people. The organization does however do community outreach programs, visiting schools and giving presentations on EDs. MEDA is a health-at-every-size facility too, which de-emphasizes the importance of BMI in determining whether or not a person is healthy or unhealthy.

Most people who come into MEDA are seeking out help from one of the specially trained Masters-level clinicians on staff, who then refer the client to further treatment in the form of weekly therapy, out-patient treatment, or residential treatment based on the severity of the client's symptoms. When a person comes in for an assessment, which costs one-hundred dollars without a scholarship, a clinician guides the client through a series of questions which allow the client, rather than the clinician, to describe the disorder in their own terms. The assessment includes questions such as a person's gender pronouns; what brought them to MEDA; when they first noticed concerns about body, weight, and food; what a person's specific ED behaviors are; whether they can identify any triggers for their behaviors; the ways in which their ED behaviors help the person cope; whether anyone in the family has issues related to body image, eating, weight, food concerns; whether the person reports a history of trauma; and the client's goals, hopes, expectations, emphasizing how MEDA can help them get there.

Although the MEDA assessment de-emphasizes individual diagnoses and provides more opportunities for the client to describe their ED in their own words, the evaluation lacks language

around discussing a client's racial identity, or how one's ethnic or racial identity could potentially be interacting with the ED. This is most likely because MEDA serves mostly a racially homogenous client population. However, the assessment is open-ended enough so that if a person wanted to bring up those issues, they may have the space to. But that would be contingent upon them being comfortable enough to do so, which may not be likely given the setting, and the demographics of the clinicians on staff. As many black and Latina women discussed in their stories, feeling comfortable enough to actually seek out help is scary when you know you may be sitting in front of someone who does not fully understand parts of your identity and/or trauma.

Conclusion

Receiving an ED diagnosis is important because "naming something, especially for the first time, inevitably changes it (Thompson, 1994, p.115). When a woman is told that she is sick, this means that the trauma that she is experiencing is real, and that an alternative life is possible. Because the ED diagnostic criteria outlined in the DSM are rigid and because clinicians do not tend to have much exposure to working with minority clients, black and Latina women were less likely to be diagnosed with and receive treatment for an ED. By moving away from the individual diagnoses outlined in the DSM, and focusing more broadly on EDs as intrinsically similar and equally legitimate regardless of the types of behaviors an individual is engaging in, women of color's experiences may begin to earn more recognition.

In the next chapter, I will discuss how sociocultural stressors are experienced by women of color, why EDs are logical responses to these forms of body-based trauma, and how these traumas can be incorporated into psychological epistemology. I will move away from talking about EDs as they are defined in the DSM, and instead work to create a new definition of EDs,

according to the lived experiences of black and Latina women. These new definitions will inform a new epistemological framework rooted in lived experiences rather than scientific texts, which will work to dissociate the link between whiteness and EDs.

Chapter 4: Eating Disorders, Trauma, and Collective Identity

The ways that the women in this sample described their relationships to food said a lot about how they thought about themselves in relation to the world around them. According to the stories included in this sample, the relationships that women had to their EDs were representative of how they coped with experiences of trauma that disrupted their bodily autonomy and sense of self. As Becky Thompson explains, “appetites are often the metaphors girls and women use to speak about atrocities” (Thompson, 1994, p.12). The way that food entered and exited women’s bodies became the primary way through which they felt they could exert control over the way their bodies felt, especially after experiencing trauma and loss of control. Food became the ultimate coping mechanism. As Stephanie Covington Armstrong describes, “I needed my bulimia in order to survive, and no one and nothing could convince me to give up what had become my sole coping skill” (Covington Armstrong, 2009, pg. 178).

Here, I will work to redefine EDs as trauma-based coping mechanisms according to the words and experiences of black and Latina women. I will specifically discuss the clash between understanding EDs in terms of collectivist and individual knowledges to explain why non-white women’s experiences are not reflected in psychological epistemology. Although white women’s stories evoked the presence of the collective experience of misogyny, the way that they integrated experiences of misogyny was individualistic. In comparison, the way that black women experienced EDs was in relationship to their collective identities as black women as well as in reference to cultural stereotypes about black femininity, particularly the strong black woman archetype (Beauboeuf-Lafontant, 2009). Latina women used EDs to communicate conflict between competing identities – Latina and American.

All of the women in the study sample, no matter their race or ethnicity, experienced various forms of physical and emotional trauma. Women's EDs played a vital role in the processing of those traumas. Women in this sample discussed experiencing traumas such as sexual assault, rape, emotional and/or physical abuse, bullying, or chronic health issues. Some sort of traumatic event occurred in each woman's life. However, black and Latina women's stories included detailed accounts of trauma that no white women mentioned in their story. These were stories of the trauma that women encountered due to racism, colorism, and acculturation. Black women in particular spoke about the explicit racial biases that they endured. Latina women discussed the stress they experienced living in families whose culture did not align with American cultural values. Black women, Latina women, and white women all experienced poverty, abuse, and abandonment. However, black and Latina women also experienced racism and oppression based on their race, language abilities, body types, and degree to which they understood and represented American cultural values. Black and Latina women discussed experiencing a form of intersectional trauma rooted in gender, race, ethnicity, and poverty which was not present within the stories of white women. Women's experiences of race or ethnicity-based trauma meant that their EDs were linked to a collective form of oppression embedded in a history of slavery, colonialism, immigration, and white supremacy.

Psychological knowledge is rooted in individualism, and this perspective is reflected in the language used to describe EDs. The discipline of psychology is committed to basing knowledge claims in data procured through the scientific method. The unit of analysis of this research is always the individual, even though research is often generalized to larger populations.

Psychological knowledge's focus on individualism is reflective of the history of psychology as a discipline, and the history of social science in the United States in general. During the rise of

psychological thought in mid-century America, the idea of the “race problem” was understood in terms of individual prejudice. This placed the onus of racism on white attitudes towards black Americans, rather than acknowledging historically-based institutional forms of racism (Gordon, 2015). This individualistic way to understand racism largely ignored the collective, institutionally based forms of racism that impact the lives of black Americans, focusing instead on individual experiences.

By taking black and Latina women’s self-narratives and embodied knowledges seriously, we see that their EDs were used as a way to cope not only with individual trauma, but also the collective traumas their communities have faced. Due to the legacy of colonization and slavery, women of color continue to experience the physical and mental repercussions of historical trauma compounded by modern day systemic oppression. The majority of white clinicians interviewed in this sample have not been exposed to or educated in these collectivist knowledges, which meant that they understood collective issues such as racism in terms of discrete interactions between individuals. Conceptualizing racism in terms of the individual dismisses the collectivist nature of racism and structural inequality. Experiences of racism and trauma described by black women, for example, are misinterpreted when understood within this individualistic framework. They are interpreted as attempting to single out individuals and their racism, rather than what individual racism represents within a larger sociohistorical context. Psychology's attempt to frame experiences in terms of the individual does not allow for the thorough incorporation of women of color's collectivist experiences into how psychological illnesses such as EDs are experienced.

White Women

One of the reasons why white women may be more likely to get diagnosed with an ED, as I discussed in the previous chapter, is because their symptoms align more with the way that psychology has defined EDs. According to the majority of research and writing done on EDs within the context of feminist psychology, EDs are more specifically understood as coping mechanisms women use to deal with misogyny and gender-based trauma. Feminist psychotherapist Susie Orbach describes that “a woman’s body is one of the few culturally accepted ways a woman has to express herself and yet the scope of this expression is limited by a contradiction: the pressure to look a certain way, to conform to today’s slim image” (Orbach, 1978, p. 189). Orbach describes women’s EDs as an expression of patriarchy on individual bodies. EDs, can, therefore, be recognized as tools used by white women to react to patriarchal norms forced upon their bodies.

Although many white women experienced trauma rooted in their gender identity, including traumas such as sexual abuse, rape, and emotional abuse, their traumas were more likely to be discussed in terms individualized experiences of gender-based oppression rather than collective experiences of misogyny. In her book *Life Without Ed*, Jenni Schaefer anthropomorphises her ED, describing a marriage between her and an abusive partner named "Ed." She describes that, “similar to a battered wife who is scared to leave her husband, a woman with anorexia and/or bulimia is afraid to leave her ED behind” (Schaefer, 2003, p. xxi). Colleen also described the power that "Ed" had over her when she stated "one of the most important promises my ED made to me was that I could escape from life as long as I had the ED." EDs were also linked to women like Kate’s relationships with males. Kate writes in her story that “If I had a boyfriend – which was mostly how I determined my worth from about age 12 – I would feel okay and at times even

attractive.” Many white women re-conceptualized their connection to the collectivist framework of patriarchy in terms of an individual relationship with the ED. Ed was personified as an abusive boyfriend, who represented both their psychological illness and their experiences as women living in a patriarchal society. White women’s experiences fit into psychological theories of the female self, where the majority of women’s trauma stems from their gender identity and their relationship to masculinity and patriarchy. Women of color’s experiences, however, did not fit into the same framework of knowledge about the female psyche.

Another way in which white women’s ED narratives emphasized the role of individuality was through their individual relationships with therapists. In particular, Jenny, Mary, Katrin, Ruth, Stephanie, Kim, and Kaitlin all described consistent relationships with therapists who helped them “get to the amazing [lives] that [they] enjoy today” (Jenni). Women described these relationships as powerful, consistent, and loving. Ruth explained that “I see a therapist whom I love, she hugs me” and Stephanie wrote that “my therapist saved my life.” Not only were these relationships positive, but they were long-lasting. Mary and Kim both saw their individual therapists for five years and Jenni Schaefer even went on to co-write her memoir with her therapist. White women’s individual relationships with therapists were focused on more than the relationships that they had with other women in ED recovery groups. Therefore, white women were able to focus more on cultivating their individual identities within the relationships they established with therapists, similarly to how they framed their identities around their relationships to their EDs when they were sick.

Black Women

Black women described their EDs within the context of their identities as black women in a society built upon violence against black bodies. Their lives could not be disentangled from the

past. Dr. Joy Degruy – a black social scientist and author— articulates the concept of “post-traumatic slave syndrome” as “a condition that exists as a consequence of multigenerational oppression of Africans and their descendants resulting from centuries of chattel slavery,” which characterizes the experience that black women in this sample were describing in their stories. (Joydegruy.com, 2018). EDs served as a way for black women to cope with the burden of having to uphold the image of the “strong black woman,” while simultaneously coping with historical and present-day trauma. EDs were one way that black women described coping with the lack of power they felt they had over their bodies. Their EDs were linked to their collective identities as black women living in a white supremacist society which poses constant threats against them.

In describing how she sees herself and understands her ED, Nicole explained that: “there is no doubt that my mom is a strong black woman. Strong black women don’t show weakness. There isn’t a script saying black women can have EDs in this society. We eat unapologetically! Black girls become strong black women! Until, sometimes, we aren’t. And what happens then?” Black feminist sociologist Dr. Tamara Beauboeuf-Lafontant discusses in her book *Behind the Mask of the Strong Black Woman* how placing the expectation of strength on black women “[obscures] black women's experiences of suffering, acts of desperation, and anger” (Beauboeuf-Lafontant, 2009, p.2). Although strength may seem to accurately define black femininity, characterizing all black women in this way is reductionist and suffocating. When black women were able to write down and make public their ED stories, they challenged the stereotype of the “strong black woman” by admitting to their suffering, and making it known publicly. This act of story-telling humanized black women as people who are not immune from suffering. Kinsey describes in her story that:

“Because of the ‘strong, independent black woman’ trope, many people, including professionals, find it difficult to believe that black women experience vulnerability and insecurity. Instead of

inquiring about our pain – physical, emotional, or a combination of the two – we are praised for our ‘strength’ and our issues go untold, or even worse, ignored.”

Kinsey, Stephanie, Shanetta, Nicole, Nettie, and Roxane all specifically referenced the idea of black female strength and the stereotype’s relationship to their ED. Kinsey, for example, could not disentangle her ED experience from her experience of being a black woman. The collective subjugation that her ancestors experienced and the racism that she has been subjected to on a daily basis directly contributed to her ED behaviors. The internalization of this degradation contributed her psychological distress. For black women, EDs were a learned survival tactic in response to societal abuse. Therefore, much of their trauma was intergenerational. For example, Stephanie described that “it took a long time for me to be able to see that my sister and I were two little brown girls who didn’t get their needs met, born to another brown girl who didn’t get her needs met, who was born to another brown girl who didn’t get her needs met” (2009, p. 222)

One of the tangible ways that black women felt the burden of history in their everyday lives was through experiencing poverty and/or food insecurity. Stephanie, Nettie, Chani, and Lakesha all explicitly discussed how their disordered relationships to food were impacted by “the insecurity of growing up not knowing if I would have enough food to eat” (Lakesha) or “not having enough which eventually internalized into not being enough” (Stephanie). EDs became the way that women were able to cope with the powerlessness that they felt within situations of poverty. These women sought to assert control over food when they had access to it, in order to maintain the façade that they were strong and able to endure the effects that historical and present day trauma had on their lives.

When black women wrote down and published their ED stories, they engaged in an act of radical independence. By turning to “what black women say for and about themselves” rather

than focusing on “appearances and expectations about Strong Black Women,” a “markedly different image of strength” was constructed (Beauboeuf-Lafontant, 2009, p.7). Black women were able to reclaim their individual stories. However, understanding black women’s experiences in terms of the black community is also an essential component to understanding their ED experiences. Black women’s relationship to the concept of “strength” linked their experiences to cultural stereotypes about black women, rooted in the history of their communities. Dr. Beauboeuf-Lafontant describes the word strength as “both a social expectation and a personal strategy” (Beauboeuf-Lafontant, 2009, p.7). She goes on to describe the relationship between eating and black female identity by explaining that “as an activity, eating enables black women to register and attend to some of their needs without disrupting the fiction of their strength” (Beauboeuf-Lafontant, 2009, p.114). It is impossible to fully understand the role that an ED plays in a black woman’s life without also understanding the relationship that she has to her identity as a black woman.

In telling their stories, black women with EDs also created a community within a community. Their words served to add to the collective consciousness of black women with similar struggles. Their words affirmed and empowered each other’s hidden pain. The formation of this community was significant, since black women described turning to their black community for support as well as survival. Patricia Hill Collins discusses the importance of community membership and community validation in *Black Feminist Thought*, describing that “in traditional African-American communities black women find considerable institutional support for valuing lived experience. Black women’s centrality in families, churches, and other community organizations allows us to share with younger, less experienced sisters our concrete knowledge of what it takes to be self-defined black women” (Collins, 1990, p. 260).

Lakesha reflected in her story that “getting treatment was extremely difficult; my insurance was not accepted and I did not see black girls like me with EDs as part of the conversation.” Chani, Nettie, and Stephanie also discussed how not being able to see other black women in treatment made recovery more difficult. Chani found herself asking “where is everyone else?” because she knew she could not “be the only black person with food issues.” Stephanie described in her memoir that “the first thing she noticed” when she attended Twelve-Step meetings was that “the room was full of women who looked nothing like me.” These women emphasized how important their identities as black women were to how they experienced EDs. The trauma associated with their blackness could not be fully understood by people outside of the black community, therefore it was important that they have access to black women with similar experiences.

Latina Women

Thirteen of the fifteen Latina women whose stories were included in this sample directly described the challenges that came with living in bicultural world. Particularly for first-generation Latinas, becoming acculturated to the United States negatively impacted the relationship that they had to their families. As Latina women realized the benefits that came with accepting aspects of white-American culture, such as peer acceptance and an increased ability to navigate through American society, they felt more alienated from their family’s culture. EDs, and particularly mixed-symptom and binge-purging type EDs, became a manifestation of the contradictory messages some Latina women received regarding their bodies and their identities as Latinas and Americans. Eating with the family connected them to their culture and their family, while purging provided them with a way to communicate the stress of acculturation, and

the internal battle over their identity. By throwing up or starving themselves, women attempted to regulate the degree to which they were being simultaneously affected by conflicting cultures.

Latina educator and author Rosie Molinary describes in her book *Hijas Americanas: Beauty, Body Image, and Growing Up Latina* that, “I learned that I can straddle multiple worlds, that I do not have to belong – and that I won’t ever belong—to one place. ‘Belonging’ is not what I was born into; it was not how I grew up; it is not who I have become” (Molinary, 2007, p. 10). In her book, Molinary weaves together her own experiences with qualitative research she conducted with over five-hundred Latina women and girls. She describes that many of the struggles that Latina women face are "born of the schism that results from living between two worlds, complicated by the ways that diverging cultures don't meet in the middle" (Molinary, 2007, p. 15). Latina women's ED stories included descriptions dualities such as American vs. Latina cultural identity, black vs. white, skinny vs. curvy ideals, and being white vs. being a classified as a "gringa" (a derogatory Spanish word for white/American person). Their inability to fit themselves into a singular descriptive category when it came to their race, body type, or cultural identity made them feel as though they did not belong anywhere, which made them more susceptible to developing and ED as a way to help regulate this internal crisis.

Molinary describes the mixed messages that Latina women receive: "be skinny, but eat our full Puerto Rican meals,' a mother might suggest. 'Do well in school, but don't think you'll be more than a wife,' a father might imply" (Molinary, 2007, p.34). The message was "you are an American, but don't act American... It was so beautifully hypocritical“(35). Molinary's desire to write a book about growing up Latina stemmed from her need to put into words the struggles she and other women face due to cultural dualism. For many Latina women, an ED is an act of independence and an assertion of divergence from their family or community culture. No longer

is a woman just identifying with the culture of her family, but she is beginning to mix in the dominant American culture which she has grown up surrounded by. However, this mixing isolates her from her family's culture and morals.

Claudia, Carmen, Viviana, Raquel, Amber, and Ahani described that their parents and families were not able to understand why they had an ED, or even how members of the family were contributing to a woman's destructive relationship with food. Amber articulates in her story that "there have been times my mother and I have not seen eye to eye; I know she does not always understand the complexities of my eating disorder." An important component of Viviana's memoir was openly discussing the fat shaming she experienced by her family. She writes that "growing up in a Latina family, I was always fat-shamed my entire life. I have also seen the abusive cycle in other Latino families." Since these women felt that their families did not understand their issues, they looked for and eventually created another community which could affirm their experiences. Telling their ED stories allowed Latina women to recognize that their experiences were not unique. Similar to black women, Latina women's identification with a collective Latina experience is what allowed them to make sense of their identities, and the role that an ED played within their struggle to make sense of where they came from and who they have become.

Pia, Gloria, and Linda described being cognizant of how their skin color affected treatment from their families and from American society. Although people of any race can identify as Latino, there is a significant amount of anti-blackness and colorism within Latin American communities. Women like Linda noted the existence of these biases in their stories, describing instances in which they were treated differently than other members of their family based on their skin color. Due to the history of colonization in South and Central America, many

Latino communities have not been able to escape a "colonial mentality," or feelings of inferiority felt as a result to colonization (David & Okazaki, 2006). Linda references the "Maldicion de la Malinche," or the Malinche's curse in her story, which is used to refer to someone who "sells out" and becomes part of the dominant culture of the colonizers. She states that "the curse of the Malinche is the informal title for a syndrome of the idea that European means better. European music? Better! European tongues? Better! And the most admired of all, European beauty." As a fair-skinned Latina woman, Linda describes an aunt telling her not to drink coke because it would make her darker. These colorist messages, coupled with the fact that she was able to pass as white in her everyday life, created an internal battle inside Linda. Should she attempt to align with European beauty standards? Or stay true to her Mexican heritage, accepting her body and her features with pride? As one participant in Molinary's study articulates, "I can pass as Latina, but I can also pass for white, so I get criticized by both sides...white people see me as a fake Latina sometimes, because I'm conveniently light for them. They expect me to ignore my ethnicity, but I never do and I never will. On the flip side, Latinos don't know whether they can trust me" (Molinary, 2007, p. 173).

White-passing Latinos as well as Latinos who have experienced significant acculturation may more easily adopt aspects of white-American culture, but this does not mean that their families or communities also understand their bodies in reference to white ideals. This contributes to feelings of isolation in Latina women who feel like members of their own community don't understand them, which is why sharing their stories and connecting to other Latina women with EDs was so important. Adriana, a young woman who describes engaging in various ED behaviors, recounts how difficult it was for her to explain her relationship to food with her mother, who does not speak English and did not grow up in the United States. Adriana

stated that: "I tried speaking to my mother about my problem but she didn't really understand. I say, that when I look in the mirror, I see that I look fat. She says that it's the mirror that's high in magnification and that she has to change it. She asks me what do I want? I can't explain to her what is going on in my head." Since Adriana's mother could not understand aspects of Adriana's identity that were rooted in the Western cultural norms about body image, and others may not understand the degree to which Adriana's Latina identity is still part of the way she sees herself, Adriana was stuck in a lonely middle ground that she felt only other Latina women with similar experiences could relate to.

The majority of Latina women in the sample discussed the idea of living in two worlds, which made it difficult for some women to label their issues with food as "eating disordered." Raquel describes that "even if you start to believe that you might be suffering from disordered eating, you're forced to explain that to a family that has little to no understanding of these illnesses and even less knowledge about how to handle them." The fact that many Latina women described experiencing poverty also led them to misinterpret their behaviors as normal instead of self-destructive. Claudia describes that "stressed from learning to speak English and adjusting to a new community after moving to a suburb of Los Angeles, California, I found comfort in sweets. I constantly ate." Gloria also chronicles that because she grew up poor, "I always had this feeling that enjoy the food while you have it, so I think that those thoughts impacted my binge eating where I felt that I had to eat it quickly and before it was gone." Raquel explains the relationship between poverty and EDs when she states in her story that "some may argue that poor and working-class people are too concerned with putting food on the table to worry about eating disorders. This way of thinking, in addition to being condescending and inaccurate, ignores the fact that EDs are mental illnesses." Living in poverty and identifying as Latina did

not protect Latina women from developing EDs. However, experiencing the world in these ways complicated how Latina women contextualized their EDs into their identity, since their experience did not align with what they were told was the ED experience.

Clinicians and Race

Black and Latina women's EDs were defined in terms of their identities as non-white women. Their cultural and community identities played a vital role in the development of their EDs. However, an integration of these collectivist experiences is currently lacking within ED epistemology. Eliane Pinderhughes, a black clinical social worker and Professor Emeritus at the Boston College School of Social Work emphasizes in her book *Understanding Race, Ethnicity, and Power: The key to efficacy in clinical practice*, that white clinicians in particular need to incorporate an understanding of collective experiences when it comes to the individual psychopathology of their patients who hold marginalized identities. She points specifically to the phenomenon of power, as it plays out within the clinician-client relationship. She writes that "exploring experiences in relation to power reinforces systemic thinking since power (or lack of power) is itself a systemic phenomenon" (Pinderhughes, 1989, p. 215). Although she is a clinician who uses psychological theory and therapy in her practice, Pinderhughes' training in social work and her personal identity as a black woman means that her perspective is more multidisciplinary when compared to the perspectives of many clinicians who I interviewed.

Since ED epistemology does not offer comprehensive multidisciplinary perspectives on the ED experience, the clinicians of color who I interviewed all discussed how their personal identity impacts how they practice psychology. One black clinician even stated that "my being black and my knowledge of self has had the largest impact on my practice" (Clinician #13). Clinicians of color interviewed for this project were able to more easily recognize descriptions of race-or-

ethnicity- based trauma as knowledge that could be integrated into psychology, rather than types of outside knowledge. This ability stemmed not from their training as psychologists, but from their lived experiences as people of color. Clinical practice, as it currently stands, does not do a good job at recognizing or integrating structural understandings of power into its epistemology, which does a disservice to people of color and other marginalized groups. Clinicians of color must turn to their own body knowledges, rather than their clinical training, to understand the experiences of their clients.

The clinicians of color who I interviewed all described that they actively work to advocate to incorporate non-white knowledges into ED epistemology. As the one Latina clinician I interviewed described:

"This field is about what someone's daily experience is in their body, and for a lot of black, brown, and indigenous folks, their bodies have been targeted which means it's not safe to be in their bodies. When you've have so much taken away from you, and you've been violated and depressed in every sense of the way, even if it's not so much your current experience, it is still in your lineage and is still present in the roles, relationships, and dynamics that happen" (Clinician #11).

Since the field of psychology has catered to the lived experiences of white people for so long, the field has not made space for the lived experiences and knowledges of people of color. It is possible for this space to be made, but it is primarily up to those within the institution to perform the necessary labor to help advocate for more culturally and racially sensitive care. Since most of the people doing this labor currently are clinicians of color who make up a tiny minority within the field of psychology, it is up to white clinicians to step up and recognize the role that they play in the perpetuation of white supremacy as it is represented through the homogenous epistemological frameworks of psychology.

It is necessary and possible for white clinicians to push for an integration of historical and cultural factors that impact women of color with EDs, as well as other people of color struggling

with mental health issues. However, this may be a challenge for white clinicians who may feel scared or timid discussing issues of race. I quickly recognized the discomfort that arises when discussing issues of race with white clinicians during my interviews. If I had more time to collect data for this project, I would have worked to operationalize some of the non-verbal messages I was receiving from many clinicians when being asked about race and white supremacy.

Part of talking about race and racism with white people is figuring out a way to make them feel comfortable, because that is the only way that conversations about race will be able to remain productive. Throughout my interviews, I struggled with whether or not to make clinicians feel comfortable after asking questions about race or power. The white privilege that the majority of clinicians possess affords them the ability to connect with similarly privileged clients in privileged spaces. They seldom have to think outside their white bubble. So when I got many clinicians into a room and asked them questions about race and EDs, it forced many of them to remember that they are not really doing much for marginalized populations. It reminded them that although they are working hard at helping people every day, they are only working to help a certain group of people.

In the next chapter, I will more specifically discuss the idea of accommodations when it comes to providing care for black and Latina women with EDs. But I think the first step in understanding how women can be "accommodated" is understanding how many accommodations people of color have given white clinicians who they have interacted with. People of color are asked as they move throughout the world to swallow the ignorance of white people. The same goes for when many black and Latina women who interact with white clinicians. The first step that white clinicians can take in providing better care for people of color is working to unlearn the personalization of racism, since racism tends to be understood in terms

of individual prejudice within clinical contexts. This leads to feelings of discomfort around topics of race which is likely to be rooted in white guilt.

People who become therapists care deeply about lives of others, and want to people live with more health and happiness. It is a selfless occupation. But it is only in looking beyond the self that clinicians can really begin to help heal their clients. The way that race has been contextualized within American society is deeply personal. It singles out individual people as racists, rather than institutions and structures as racist. Therefore, many white people feel that by bringing up race, they are being racist. It is not until white clinicians are able to confront the racism that has directly benefited them that people of color will be able to benefit from their clinical expertise. This requires less of a psychological lens, and more of a sociological and political perspective on bodies within American culture.

Clinicians must push to move beyond simply having an awareness of the existence of racism. Many clinicians I interviewed discussed being aware of their “own prejudice,” or their role “as a middle-class white woman who had a lot of privilege” (Clinicians #12, #10). Others talked about “never forgetting” a time in which they heard from a person of color about their ED, placing their understanding of how a group of people experience EDs on one person’s perspective (Clinician #9). Although this sort of awareness is the first step, stopping at awareness creates a perpetual me versus them mentality, where the experiences of people of color occur outside and below the experiences of white people. This means that the knowledges of people of color do not belong alongside the dominant white knowledges that clinicians have been trained in. Of the five clinicians who explicitly noted the relationship between sexism, racism, trauma, and EDs, only one of those clinicians was white. Even though white clinicians may be entirely aware of the existence of racism and inequality, they are unable to integrate that understanding

into how they think about and treat mental health issues such as EDs. They may think that because they are not explicitly racist, that they are not perpetuating racism and inequality. However, clinicians will continue to fail their minority clients if they don't realize that racism and inequality persist even if their individual intentions are non-racist.

Conclusion

Black and Latina women's EDs were linked to their experiences within the racial and ethnic communities they identify with. Latina women framed their EDs in terms of their dedication to their families and community, as well as the struggle of living in two conflicting cultures. Black women affirmed their membership to the black community by referencing each other's experiences, and contextualizing their ED experiences in terms of the strong black woman archetype. White women they made sense of their EDs in terms of individual relationships rather than the types of collective experiences described by women of color. Psychology's individualistic framework hinders the incorporation of racialization and collective trauma into epistemology, which creates fear and potential avoidance around topics related to race and inequality especially amongst clinicians who do not hold marginalized identities.

Chapter 5: Treatment and Accommodations

In the previous chapter I discussed how black and Latina women's collective identities framed their ED narratives. In this chapter, I will discuss how women described their interactions with different types of mental health and ED treatment, focusing the concept of treatment accommodations as understood by women who suffer from EDs and clinicians who treat EDs. I will specifically discuss why current accommodations do not provide equitable access to Latina and black women with EDs when compared to white women due to issues related to the cost and location of treatment, as well as the racial and cultural homogeneity of treatment resources. Non-white women described feeling alienated from ED treatment not only due to issues relating to insurance coverage, transportation, and knowledge of available resources, but also due to complex feelings they had towards establishing relationships with clinicians who they felt did not understand their experience, and who represented the ways in which white supremacy exists within healthcare. Therefore, black and Latina women's collective identities, which played a large role in how they conceptualized their EDs, also dictated their treatment experiences. Although black and Latina women may have been projecting their experiences of social marginalization onto the clinicians they interacted with, that does not make their experiences any less legitimate. I will conclude by discussing issues of treatment accommodations from the perspective of clinicians who work hard to provide the best possible care to their clients. However, I will focus on the importance of advocating for more clinicians of color who specialize in treating EDs in order to improve the experiences that black and Latina women with EDs have in seeking out and receiving psychological and medical care for their EDs.

Getting Help

Determining what sort of treatment is necessary for a woman with an ED is difficult. Accessing treatment requires that a woman has insurance, can receive referrals from a medical or mental health professional knowledgeable about EDs, has time for appointments, and has the ability to take time off of work or school. While on a visit to the Renfrew Center of Boston I was able to get a better idea of what it is like for a woman to navigate treatment. Renfrew Boston is not a residential treatment center; however, it does provide outpatient treatment for women who need it, granted they are able to get insurance coverage or pay out of pocket. These outpatient services include resources such as individual therapy, recovery groups, and nutrition support. A woman's first interaction with Renfrew usually occurs when she or someone who cares about her calls in to hear about the available services. Most women are referred for treatment by a therapist, but a professional referral is not required to receive treatment. Accessing Renfrew's resources is as easy as picking up the phone. When a woman calls Renfrew, she is taken through a series of questions with an intake coordinator including basic demographics and insurance information, questions about symptoms, and finally the scheduling of an intake assessment at Renfrew which requires a woman to receive lab work before the appointment such as a blood draw and EKG test.

Renfrew's services include first determining what level of care a woman needs. Inpatient treatment is reserved for the most medically and psychiatrically severe cases as determined by DSM diagnostic criteria, and includes a stay on a hospital ward (NEDAa, 2016). Residential treatment is more of a therapeutic living environment for individuals who are medically stable but psychiatrically impaired. These individuals need more care than just a partial hospitalization or outpatient program, and live in a community of people who are also suffering from EDs. For

those who may not have access to or who may not require living in a residential setting, outpatient programs are available, such as the programs offered at Renfrew Boston. Outpatient treatment is recommended for people who are medically and psychologically stable, but whose ED symptoms are interfering with their daily lives. Outpatient treatment can be as intense as attending treatment five days a week, or include treatment three days a week for three hours a night. No matter the intensity, women in these programs attend groups with other women in treatment, work in individual and family therapy, as well as meet with a nutritionist and psychiatrist regularly.

Within the sample of women whose stories I included in these analyses, many had access to general healthcare resources as well as residential treatment. However, white women were far more likely to have access to healthcare and treatment than black and Latina women were. Ninety-six percent of white women had access to general healthcare resources such as a primary care doctor, and 84% were able to attend residential treatment. As Stephanie (white) explained in her story, “I was very lucky. I had good insurance—it allowed me to stay in program for 8 weeks and then continue with an amazing outpatient team.” In comparison, only 53% of Latina women and 60% of black women described having access to general healthcare resources. Half of the black women in this sample had access to a form of residential or outpatient ED treatment, while only 40% of Latina women did.

White women had the most access to residential ED care, which meant that they had the time and funds necessary to immerse themselves fully into a healing environment with help from various professionals. White women’s stories were largely devoid of discussions about how they sought out care, or the difficulties of achieving insurance coverage. Their stories made it seem like all that was necessary to receive ED treatment was a desire to get better. As Colleen wrote,

“please remember that getting an ED is not a choice, however, getting help is.” Additionally, 80% white women also characterized their interactions with healthcare providers positively, while only 20% of Latina and 25% of black women felt that their interactions were positive. Black and Latina women’s stories made it clear that receiving care was not simply choice, and required sometimes unattainable resources. In telling her story, Raquel (Latina) incorporated a critique of the way in which treatment modalities are currently inaccessible to many people struggling with EDs. Raquel explains that:

“Recent research shows that women of color are less likely to seek treatment for an eating disorder than white women are, for a variety of reasons. For one thing, help is expensive. Residential treatment programs cost \$30,000 a month on average. Most patients require at least three months of this treatment, bringing that fee up to \$90,000. For those lucky enough to have insurance (I was not one of them), most providers will not cover long-term treatment.”

Forty percent of Latina women and 30% of black women described specific negative interactions they had with healthcare providers or healthcare institutions, and many of those negative interactions had to do with monetary resources or insurance coverage. Additionally, black and Latina women felt as though the care available to them was not catered towards their best interests. Viviana (Latina) describes in her story the lack of support that she received, even after trying to get help: “I did not even have an eating disorder group at all. The therapist would fat-shame me. I had no one and felt so alone. Sharing my story was something I had to do all on my own without a support system.” Although Viviana wanted to get better, she did not have the ability to seek out treatment in an environment that was accepting and understanding of the relationship between her body, her ethnic and racial identity, and her ED. Much of this had to do with economic resources, but as a Latina woman with “atypical anorexia” it was also hard for her to find a space in which she could feel supported. Viviana’s story diverges from the positive experiences of treatment that white women like Stephanie recounted. As mentioned in the last

chapter, Stephanie writes in her story that, “my therapist saved my life,” and also includes that “it was not until I admitted myself into an intensive program for eating disorders that I truly began to live a life worth living.” She even admits that “I was very lucky. I had good insurance... Not everyone is as lucky as me but that does not mean you cannot recover too.”

Accessibility

Accessing ED treatment was more difficult for many black and Latina women for economic and logistical reasons. For one, they didn't have the same level of family support that white women did, making it harder for them to do things like take time off of work to get treatment. As Gloria (Latina) explained, "my schedule was all over the place and would change continuously so I was not able to keep up with my appointments because clinics tend to close at five." Kimberly (black) wrote about having to take "two cabs across the state of Massachusetts to an inpatient facility," and that "it took 10 years for me to be hospitalized for my eating disorder." Chani (black) explained the experience of looking into treatment on her own and finding out that there were very few programs that treated binge eating disorder, despite the fact that she was “surrounded by three world-class hospitals.” She also described the programs that were available “had nothing designed for a working person’s schedule, which reinforced my belief that only the rich can afford treatment.” When she finally did find a place to receive treatment, “it was at a facility that only accepted private insurance,” and when she got the bill for the cost of treatment, “I couldn’t believe the total, or imagine how I could possibly pay it.”

Treatment logistics and the economics of insurance coverage were not the only barriers to treatment that women of color faced. Clashing cultural and community values also led women of color to feel out of place. Amber described in her story that "I grew up in a household where therapy was considered 'airing your dirty laundry.'" After Amber booked an appointment with a

therapist, her father pleaded with her to "please don't tell anyone about this. It's no one's business but our own." Since therapy often times highlights the problematic aspects of interpersonal relationships, such as the relationship that a woman has to her parents or family, the bonds that have allowed Latino communities to be cohesive and strong can be disrupted. Amber's father may have been afraid that entering therapy would disrupt the relationship that his daughter had to her community. However his wariness became a roadblock to Amber's recovery since a large component of recovery is a woman's ability to depend on her "support network." The idea of a "support network," which is heavily emphasized within dominant narratives of mental health recovery, individualizes the concept of community by placing the emphasis on the individual and their experience rather than the interconnectedness of the community's experiences. Since many women of color's communities were not able to understand their experiences with EDs, women were unable to utilize their communities as support networks, which could have aided in offering women of color the opportunity to be recognized within their communities for their individual suffering. Ultimately, therapy and mental health treatment were not something that Amber's family were readily able support her in, which set her up for a more difficult recovery journey.

For many non-white women, there were certain social advantages to not telling their story. By staying silent, women were able to protect their communities. By not speaking about their EDs, they could project to the world that they were strong resilient women, capable of surviving in a white supremacist culture. However, this silence is what has made it so difficult for non-white women to find other women like them who were having similar experiences. This, in turn, made recovery for non-white women more difficult since having a supportive community is so important to how they understand their individual identities. Chani discusses the importance of the presence of a black community with her story. Although Chani admits that she had an

overall positive experience of treatment, she also states that "sometimes I struggled with the racial gaps between us. I was the only person of color in my program. 'Where is everyone else?' I thought. I cannot be the only black person – even half-black – with food issues." Because Chani felt isolated in her identity as the only black woman in her treatment group, this communicated to her that she was an anomaly, even though she knew "I cannot be the only black person with food issues."

Nettie (black) chronicles a similar experience, noting that her treatment program "seemed to be focused mainly on those who suffered from anorexia. In my group, I was the minority – the only black woman and one of two women in their prime. I was the only one suffering from BED." Both Chani and Nettie characterized their experiences in treatment as isolating due to the lack of diversity present within the treatment space. Although they both had positive responses to treatment, the lack of diversity made them feel out of place, and communicated that people who looked like them were not meant to take up space in ED treatment facilities. The lack of cultural and racial diversity that black and Latina women observed made it hard for them to feel welcomed in treatment settings. It even made it difficult for women like Stephanie (black) to put trust in the care that they were seeking out. Stephanie explains that: "I know of many hospital programs and inpatient recovery programs that work miracles, but I did not have the financial means or the health insurance to be able to afford those. Nor would I have trusted specialists to help me" (Covington-Armstrong, 2009, p.vii). It requires a substantial amount of trust for women to seek out and complete ED treatment, especially since it may require a woman to expose to others the struggles that face her community. And if women are coming from a place of distrust not only because of their ED but also because of their racial or ethnic identity, then it becomes even less likely that they will actually seek out traditional care.

Alternative Treatment Settings

The lack of trust that Latina and black women felt towards institutions of medicine and psychology led some to seek out alternative forms of treatment which did not take the form of the outpatient, in-patient, or residential care that 84% of white women described. Stephanie recounts her experiences attending Twelve-Step meetings, which she relied on because “I hadn’t found another way that I could afford or that worked” (2009, p. 218). She writes that “I knew that there were other ways” to get treatment, but she had not had access to any of them, or felt comfortable in them. Although Stephanie describes being one of the only black girls in the meetings, she wrote that “as I became more comfortable with admitting my ED, many sister-girlfriends admitted to also being bulimic and anorexic, and I’d encouraged them to seek help.” In becoming part of an ED recovery community of women who did not look like her, she was able to incite a conversation within her black community.

Stephanie goes on to write about how:

“Over the years, I would meet a bunch of other black girls who did come to a meeting, but rarely would they stay. I’d run into some of them at church or get-togethers, but they usually didn’t come back to the meetings. Most girls chose not to share their private issues in a room full of white girls, but that choice had been made for me – I needed program.” (2009, p.215)

Stephanie “needed program” to help her recover, which is what made her stay in it despite her feelings of alienation. Even though Twelve-Step meetings were outside the realm of more traditional outpatient or residential ED treatment, it was still homogenous in its demographic. This homogeneity made black women like Stephanie uncomfortable, even though the form of treatment may have been a more economically and logistically accessible for them.

The fact that ED treatment has been historically built upon Western medicine and Eurocentric ideologies also left Gloria (Latina) feeling out of place. The language of recovery and the way in which EDs are conceptualized as existing in relationship to Gloria’s identity did

not align with how she understood herself and her ED. In response to this incongruity, Gloria created Sage and Spoon, a support group for people of color with EDs. Gloria explains that “we need to create our own healing opportunities. You don’t have to have money to create healing. The healing is already amongst ourselves.” By relying on her identity as a person of color, Gloria has been able to create a space for collective healing, rooted in a common acknowledgement of the difficulties many non-white individuals have undergone in seeking out more traditional ED care.

Treatment and Recovery

Twenty-two out of the twenty-five white women whose stories were sampled here identified as recovered from their ED. In comparison, only five of the fifteen Latina women and nine of the twenty black women felt as though they were completely recovered. The fact that twenty-one black and Latina women within this sample were unable to identify with the term “recovery” is indicative of how disconnected non-white women felt from the world of EDs within psychology and medicine. It was also reflective of the fact that black and Latina women did not have access to psychological and medical care to the same degree that white women did, making them less likely to define themselves as having conquered their disorder.

Gloria (Latina) explains her relationship to the idea of recovery by stating:

“We need to stop romanticizing and giving this binary view of recovery and non-recovery because for me my eating disorder is always going to be part of me. This is going to be something that stays with me for the rest of my life, and it’s just a matter of learning to make continual peace with my body. Recovery to me is not my choice of word, I prefer to say healing because its continual.”

Gloria’s articulation of not feeling connected to the idea of recovery is largely due to the fact that recovery is understood as a binary where an individual is recovered or they are not. In reality, Gloria makes it clear that recovery is a process which will most likely include relapse

into old ED behaviors. Gloria does not connect to the term recovery because she knows that she will continue to struggle as she makes peace with her body wholly as it moves through a white supremacist world.

Not all black and Latina women felt the same way as Gloria. Shanetta, GeChonne, and Brittany all claimed they identified as recovered or on the path to recovery in their stories. GeChonne (black) stated that “I can say with confidence that I am truly done actively entertaining the disease.” Brittany (black) admits that “anorexia is a life-long battle, and I know that I will always be in recovery.” Recovery was described by some black and Latina women as an action rather than a destination. Part of the reason why women of color may be more likely to describe their ED journey in this way is because the act of loving themselves extends beyond just the body hatred that stems from their ED. It also extends to loving themselves despite the misogyny, racism, and anti-immigrant rhetoric they hear every day. It is learning how to nourish their bodies and affirm their own identities continuously. Therefore recovery is not a place that non-white or women of color can comfortably arrive. Recovery means a return to the survival mode that has allowed communities of color to sustain themselves throughout history.

In describing why Sage and Spoon only welcomes people of color, the website explains:

“Most of the information and recovery resources presented around eating disorders are formed around a white, middle class, heterosexual, cisgender, background that do not speak to PoC, queer* or transgender individuals. In order for our healing to work, it must be done in our community and away from spaces where we have to validate ourselves, educate others about our lives, or potentially experience emotional triggers. People of color NEED their own spaces without apology” (Sage and Spoon, n.d.)

Sage and Spoon represents the kind of community-based healing that some black and Latina women described wishing they could have had access to.

Clinicians and Accommodations

Accommodations refer to the ways in which clinicians or treatment centers try and make themselves more accessible and convenient for potential ED patients. In trying to understand how clinicians make sense of racial and ethnic disparities within ED treatment, I asked clinicians a lot about the idea of accommodations. The way that accommodations are understood and provided within the context of ED treatment was revealed to be largely monetary. These accommodations come in the form of insurance coverage, treatment scholarships, and geographic accessibility. Accommodations were also more indirect, including tools such as community outreach and education, which could allow more individuals to recognize that there are resources available to them if they wanted to seek out psychiatric care. These kinds of accommodations stem from the idea that women of color and other marginalized groups may not know how to seek out help for an ED.

Most accommodations related to providing monetary resources to women. According to Beth Meyer, the head of the Multi-Service Eating Disorders Association (MEDA), there is a direct relationship between the accommodations and money. Beth described to me that "I do not think we do a good job being accessible to marginalized populations. Mostly because of money." Even when thinking about going into areas where MEDA could potentially serve more ethnically and socioeconomically diverse clients, she admits that even if people from lower resourced communities wanted to get treatment, "what am I going to say? The reality is there are no resources, or very few." Therefore, her work as a clinician remains stagnant in its ability to reach marginalized populations, who are likely to face barriers to treatment due to lack of economic resources.

In order to try and make their treatment resources more financially accommodating, some clinicians take on pro-bono clients or offer treatment scholarships. Half of the clinicians I interviewed discussed having this option available for clients who needed it. Another accommodation that clinicians made related to insurance coverage. Five clinicians noted that they worked hard to ensure that they can take many types of insurance, some even including Medicaid. Other clinicians understood accommodations from a more logistical lens, noting that their office was easily accessible through public transit or even a walking distance from potential clients on a college campus. Seven clinicians I interviewed noted their physical accessibility as a major kind of accommodation. This does not necessarily include accessibility for those who are physically disabled, although some clinicians have spaces that could accommodate both disabled and able bodied clients.

The less tangible accommodations that clinicians struggled with had to do with the fact that almost half of clinicians realized that many non-traditional ED sufferers may feel misunderstood by healthcare providers or not have a way to seek out help from mental health professionals which may keep them from seeking out care. For example, clinician #1 described that one of her goals as a clinician is to "start getting [educational resources] into areas that are isolated" as well as "areas where significant populations of people don't have an awareness of services and desperately need them." Therefore, clinician's conceptualization of accommodations extended beyond insurance coverage and transportation. It also acknowledged the difficulties that women may have due to feelings of isolation and confusion about how EDs are experienced and who they are experienced by. By recognizing that outreach was necessary, clinicians were able to indirectly acknowledge the fact that ED treatment communities are overwhelmingly white.

Most clinicians I interviewed were honest about the racial homogeneity present within the ED field, with one clinician even noting that "it doesn't help that we are all white and blonde" and also stating that her practice needed to include "a more diverse staff" (clinician #10). The racial homogeneity within clinician populations who specialize in treating EDs is apparent, and was instantly recognized by non-white women with EDs women who tried to find ED care or those who entered into treatment. Erika, a black woman who shared her story on *Ebony.com*, alluded to the feelings of distrust that arose out of interactions with healthcare when she wrote about how within her community, people deny "the existence of a problem that might require *actual* psychiatric care," which has led to the perpetuation of "the idea that psychiatric care cannot and will not help us uncover the tools we need to overcome our battles." Erika recognized the importance of finding ways for black communities to benefit from psychological treatment methods. However, she also brought up the feelings of distrust that black communities have towards psychiatric care. The lack of treatment utilization within black (as well as Latino) communities does not stem from a diminishment of the seriousness of mental illness, but from a learned distrust between black and Latino communities and white-dominated institutions.

White clinicians represent the perpetuation of Eurocentric values within medicine, and are therefore the embodiment of institutions that have failed people of color. The domination of white psychologists within the institution of psychology is representative of just how omnipresent white supremacy is within the United States. It is important to emphasize that I am not singling out white clinicians who specialize in EDs as perpetuating white supremacy by working tirelessly to serve their patients. I am, however, pointing out how for non-white women who discussed their experiences within ED treatment, the white clinicians they encountered represented the many forms of marginalization that led them to develop an ED in the first place.

Clinicians of Color

The racial and ethnic identities of clinicians of color clash with the dominant whiteness of psychology; therefore, their presence serves to represent the communal identities of people of color in need of psychological care. Having the opportunity to speak to or receive treatment from a clinician of color can afford a woman of color the opportunity to feel safe in a treatment environment, or feel confident enough to call a treatment facility about their resources.

GeChonne, a black woman who shared her story, described a particularly salient interaction that she had with a counselor who was able to mirror her experience as a black woman. GeChonne recounts that:

“When I told my counselor [about my eating disorder] she didn’t dismiss me; she wanted to talk about my life before, during and after my bulimic tendencies. We were both of Caribbean descent, so she heavily related to the ‘before’ part because she too had struggled with her weight but said had never reached the point of an eating disorder. ‘Women like us, you know... That’s just... That’s just not heard of, unfortunately.’”

In talking to a clinician who was also “of Caribbean descent,” who was able to connect with GeChonne through a discussion about “women like us,” GeChonne felt like her ED experience was being seen and understood fully as it existed within her relationship to her collective cultural and racial identity, as well as her identity as a woman.

The impact that having another person that looks like you within the world of psychology was also discussed by the clinicians of color in their interviews. One black clinician revealed that “Because all of my degrees are from [Historically Black Colleges or Universities], it perhaps won’t be surprising that 90% of my professors were black at each institution. Access to those persons, to relationships with them were integral to my learning. It was essential to my ever-developing self-concept to see scholars who looked like me” (Clinician #13).

Solely increasing the amount of racial and ethnic diversity of clinicians who treat EDs will not solve the disparities in treatment amongst women of color with EDs. However, the presence of differing values and perspectives within the institution of psychology may make the space a

more welcoming and comfortable for women of color to inhabit, which would likely make a positive impact on the amount of trust that communities of color put into medical and psychological care.

Conclusion

ED treatment accommodations do not account for the lack of trust that women of color have towards the institutions of medicine and psychology, since accommodations tend to focus only on financial and logistical needs. In response, some black and Latina women have found ways to accommodate themselves and their communities through the use of community healing tools. Clinicians of color represent the melding of two sets of values – the values of the marginalized community identity that they identify with and the individual psychological perspective they have been trained in. When black and Latina women with EDs have the opportunity to interact with clinicians of color, they recognize that these clinicians are able to use their experience-based and professional knowledges to cater to both the collective and individual experiences that are tied to Latina and black women's EDs. Therefore, in order to provide appropriate treatment accommodations to Latina and black women with EDs, more diverse treatment settings and treatment providers must be made available to them not only for individual treatment, but to diversify treatment environments.

Chapter 6: Conclusion

In 2014, when she was a senior in college, Kinsey published her story online in an article titled “When Black Girls Don’t Eat: Examining the Silence Surrounding Our Eating Disorders.”

She opened the article by stating:

“When someone mentions ‘eating disorder,’ what comes to mind? Stick-thin, hollow-cheeked white girls with purple bags under their eyes is the typical image people conjure in their minds. It dominates the media: images of Hollywood starlets wearing their clothes large and baggy in an attempt to hide their bodies. In this dominant image is the erasure of the black and brown women who also face various eating disorders, erasure of the pain these women face, and erasure of the reality that eating disorders are not just a white woman’s disease.”

In telling her story, Kinsey acknowledged the erasure not only of her own ED experience, but the erasure of all women of color with EDs who have been ignored within the white-washed world

of EDs. Because women of color have yet to be equitably represented within ED media,

literature, and research, women like Kinsey have created their own forms of representation.

Currently, Latina and black women with EDs are the only experts of their experiences.

Psychologically-rooted ED epistemology – as it currently stands— does not benefit women of color in the same way that it benefits white women. Black and Latina women continue to be forced to fit their collective identities into the individualistic framework of EDs. The incongruity between how psychological epistemology conceptualizes EDs and how black and Latina women experience EDs has led non-white women to suffer for far too long. EDs are not just “a white woman’s disease,” and it is time that they are redefined in order to create more inclusive epistemologies.

EDs are understood in reference to whiteness which has served to maintain white supremacy in ED diagnosis and treatment. In order for women of color to be equitably diagnosed and treated for EDs, the diagnostic criteria for EDs must change. Diagnostic criteria continue to be defined in reference to the white bodies on which the criteria were created. This was evidenced

by the fact that although every woman in this sample described ED behaviors in their stories, white women were most likely to have received an official ED diagnosis by a clinician. More multiracial and multicultural perspectives must be included within diagnostic criteria if we hope for all people to receive proper ED diagnoses and treatment. Diversifying the DSM will only occur if clinical training also includes information on how to recognize and advocate for issues related to both individual and institutional racism, colorism, classism, and sexism. If medicine and psychology hope to be able to treat more diverse populations, they must include issues of diversity and race within pedagogy.

Race, ethnicity, and culture are collective experiences which have not been consistently incorporated into psychological epistemology. Black and Latina women's EDs were simultaneously tied to their individual identities as women as well as their collective identities within Latino and black communities. Black women within this sample discussed how their EDs existed in relationship to the black community, as well as in relation to stereotypes about black femininity. Latina women's EDs were described as being tied to their bifurcated cultural identities as both Latina and American women. In comparison, white women's experiences were rooted more firmly in their experiences of individuals experiencing sexism as it affects their own body, while masking how sexism is collectively perpetuated within the patriarchal American society. ED diagnosis and treatment is largely devoid of language regarding the collective experiences of race or ethnicity, which means that clinicians do not have the tools to speak confidently about issues related to race and white supremacy, even if awareness of these issues exists. The lack of acknowledgement towards how white supremacy exists within clinical settings further marginalizes Latina and black women who attempt to seek out help for their ED.

The ways in which EDs are currently presented, diagnosed, and treated also make it difficult for black and Latina women to put their trust in the care available to them. Treatment accommodations related to monetary resources and physical accessibility are vitally important, but do not address the lack of trust that black and Latina women have towards dominant treatment institutions. This lack of trust is warranted based on negative experiences that many people of color have had while interacting with the institutions of psychology and medicine. Currently, diversity within ED treatment providers must be achieved in order for more women of color to feel comfortable seeking out help in these predominantly white environments.

Study Limitations

Although the women included in this sample were diverse in their racial and ethnic identities, claims of generalizability must be made cautiously. I cannot know for sure how representative this sample is of the majority of black, white, and Latina women suffering from EDs, since the sample included only women who have had the opportunity to publish their stories through social media or more formal mediums. What I can say for sure is that there is much work to be done to make ED diagnosis and treatment a more equitable processes. Institutionally-legitimated knowledge about EDs is aligned with white values of individualism, rather than the collective experiences these women of color described being so vitally important to their identities. More perspectives must be accumulated from racially and ethnically diverse women with EDs to help understand the role that story publication had on the details that women chose to disclose in their stories.

The difficulties that I encountered in attempting to obtain stories from Latina and black women with EDs is representative of the amount of progress that must be made in establishing visibility for non-white, non-cis-gender, non-thin, non-straight, women with EDs. A number of

women included in this sample identified as queer, however I was unable to fully incorporate a discussion of how this aspect of their identity impacted their ED due to my focus on race, ethnicity, and culture. I have no doubt that these aspects of identity serve to further marginalize individuals, causing psychological distress, which may lead them to seek out coping mechanisms such as EDs. This assumption is backed by research, such as a 2015 study which found that transgender college students, when compared cisgender students, were four times more likely to develop anorexia or bulimia and two times as likely to develop ED behaviors such as purging (Diemer et al., 2015). The link between social marginalization, body image, and mental health must be studied further in order to assess how a more integrative understanding of social factors can be incorporated into epistemological frameworks that govern the diagnosis and treatment of EDs.

Future Directions

All the clinicians I interviewed were concerned with the lack of diversity within ED diagnosis and treatment. However, there was an apparent difference in my ability to discuss issues of race with clinicians based on their personal racial and ethnic identities. The level of discomfort that I felt in discussing issues of race with white clinicians could have been due to my own transference as a non-white woman discussing issues of race with white individuals; however, I believe that the discomfort that I felt was partially produced by some clinicians. Talking to white people about race can bring up complex feelings related to race-based power dynamics, guilt, as well as feelings of powerlessness from white people who do not know how to deal with their unearned white privilege. Future research should continue to investigate how a clinician's personal identity impacts their ability to integrate issues of racism and other forms of social marginalization into their practice with clients who hold socially marginalized identities.

The relationship between EDs, treatment, and the medical industrial complex and the impact that these relationships have on treatment accommodations must also be explored further. In her work as an activist, Gloria Lucas often talks about the relationship between racism, historical trauma, psychiatric care, and the medical industrial complex. Gloria describes that, "historically, the medical industrial complex has not been here for people of color." The values of the medical industrial complex reflect the institution's focus on individuals as profit creators, rather than individuals in need of personalized community-based care. Future research should continue to emphasize and integrate how the medical industrial complex decreases the quality of care that all individuals receive as more emphasis is placed on an individual and their economic value, rather than their personal wellbeing.

Where We Go From Here

At present, institutional barriers related to healthcare access, treatment funding, and insurance formalities continue to be large roadblocks in making ED diagnosis and treatment more equitable. These institutional barriers, coupled with the homogeneity of ED epistemology, mean there is a lot of work to be done. However, awareness around these issues has increased, and activists continue to work to challenge institutional frameworks of ED knowledge. In March 2018 two crucial articles were published addressing issues of EDs, race, and body politics. One of those articles was published on the Three Birds Counseling and Supervision blog, titled "Diversity is a Good Thing: 80+ Eating Disorder & Body Image Providers & Activists." While reading through this list of diverse clinicians and activists, I was simultaneously empowered and disheartened. It was empowering to see the largest group of diverse ED clinicians and activists I have come across through my research, but also disheartening to think that there is still so much work to be done. I am optimistic that the recognition that "diversity is a good thing" is a step in

the right direction and will make more people question why EDs continue to be so closely aligned with whiteness.

The second article was published on a private blog by one of my favorite ED writers and activists, Melissa Fabello. The article, entitled “An Open Letter to ‘Apolitical’ Eating Disorder Professionals” addressed the fact that EDs should be recognized as a political issue. In her article Fabello states that:

“The idea that we can avoid taking a political stance in eating disorder work is impossible. Because when we think we're being apolitical, we're really just upholding the status quo [...] That is to say, if we don't actively choose to *change things*, then we're complicit in keeping them the same. We're allowing them to stay the same. We're giving up the fight – or never taking it up at all. And because the way that things currently are is *fucked up*, we have to do something. And that thing has to be active and deliberate. It's also oftentimes scary.”

Fabello's words encapsulate the point of this thesis perfectly. EDs are a political issue. The politics of race, colorism, misogyny, poverty, xenophobia, and colonization cannot be ignored since they impact how people live in their bodies. Currently, the way in which EDs are diagnosed and treated serve as an act of complicity to dominant white-supremacist epistemological frameworks which have excluded people of color. I have confidence that things can change, but know that there is still much work to be done.

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Methodological Appendix

Women's Stories: Demographic Information and Links

Name (Race/Ethnicity)	Story Source	Date Published	Date Accessed	Primary ED Behaviors
Adriana Rodriguez (Latina)	Heritage Radio Network Podcast	February 15 th , 2016	May 2017	Restriction
Katherine (Venezuelan)	YouTube	March 13 th , 2017	May 2017	Restriction, Binge Eating / Purging
Linda Rivas (Mexican-American)	The Shorthorn Article	April 17 th , 2017	May 2017	Disordered Eating
Gloria Lucas (Mexican-American)	Food Psych Podcast Episode 103	May 8 th , 2017	May 2017	Bingeing/Purging
Diana (Venezuelan)	YouTube	May 24 th , 2017	May 2017	Restriction, Binge Eating / Purging
Roxane Gay (Black, Haitian- American)	Memoir— Hunger: A Memoir of (my) body	June 13 th , 2017	June 2017	Binge Eating, Purging
Amber Gonzalez (Latina)	NEDA Blog	2017	July 2017	Restriction, Purging
Instagram User 1 (Puerto-Rican)	Instagram	2017	May 2017	Restriction, Binge Eating
Instagram User 2 (Black, Biracial)	Instagram	2017	May 2017	Restriction
Lakesha Lafayette (Black)	NEDA Blog	2017	May 2017	Restriction
Sheryl Cruse (White)	NEDA Blog	2017	May 2017	Restriction
Katrin Alyss (White)	NEDA Blog	2017	May 2017	Restriction
Jennifer Kreatsoulas (White)	NEDA Blog	2017	May 2017	Unspecified Eating Disorder Behaviors
Liv Oricheiella (White)	NEDA Blog	2017	May 2017	Restriction, Purging
Dana Land (White)	NEDA Blog	2017	May 2017	Restriction, Purging
Christina Fisanick Greer (White)	NEDA Blog	2017	May 2017	Binge Eating
Kate Greenan (White)	NEDA Blog	2017	May 2017	Binge Eating, Purging

Nikki DuBose (White)	NEDA Blog	2017	May 2017	Restriction, Binge Eating, Purging
Kaitlin Irwin (White)	NEDA Blog NEDA Blog	2017	May 2017	Restriction, Unspecified Eating Disorder Behaviors
Kashia Wells (Black)	Myblackmatters.com	February 26 th , 2016	May 2017	Disordered Eating
Shanetta McDonald (Black)	Refinery 29	February 29 th , 2016	May 2017	Restriction, Binge Eating
Pia G (Latina)	Adios Barbie	March 7 th , 2016	May 2017	Restriction
GeChonne Laurent (Black)	The Odyssey Online	April 4 th , 2016	May 2017	Restriction, Binge Eating, Purging
Michelle Goncalves (Venezuelan)	YouTube	Sep 18, 2016	May 2017	Restriction, Purging
Viviana Rose (Mexican-American)	Memoir— How American Diet Culture Negatively Affects Latinas	October 10 th , 2016	June 2017	Restriction
Kimberly Neil (Black)	Teen Vogue	December 9 th , 2016	May 2017	Restriction, Purging
Nettie Reeves Lewis (Black)	Memoir— Through THICK and Thin and Thick Again: A Black Woman's Journey with BED (Binge Eating Disorder)	2016	June 2017	Binge Eating
Chani Coady (Black, Biracial)	NEDA Blog	2016	May 2017	Binge Eating
Jamie Bushell (White)	NEDA Blog	2016	May 2017	Restriction
Emery Gewirtz (White)	NEDA Blog	2016	May 2017	Restriction
Raquel Reichard (Puerto Rican)	Mic.com	2015	May 2017	Restriction, Purging
Nicki Domonique (Black)	YouTube	June 21 st , 2015	June 2017	Restriction, Purging
Robbie Ann Darby (Black)	The Root.com	July 12 th , 2015	May 2017	Restriction
Yovana Mendoza (Mexican-American)	YouTube	August 12 th , 2015	May 2017	Binge Eating /Purging
Lindsay (White)	MEDA Blog	2015	May 2017	Restriction
Ruth Taylor (White)	MEDA Blog	2015	May 2017	Restriction

Kim (White)	<u>MEDA Blog</u>	2015	May 2017	Restriction
Carmen Cusido (Cuban-American)	<u>NBC Latino</u>	March 8 th , 2015	May 2017	Restriction
Ahani Ortega (Mexican-American)	<u>slate.com</u> & <u>Latinousa.org</u>	March 21 st , 2014	May 2017	Restriction, Purging
Ali Prett (Black)	<u>The Thought Catalogue</u>	March 31 st , 2014	May 2017	Purging, Restriction
Abiola Abrams (Afro-Caribbean)	<u>Huffington Post</u>	May 14 th , 2014	June 2017	Binge Eating
Nicole Weaver (Black)	<u>xojane.com</u>	December 22 nd , 2014	May 2017	Restriction, Purging
Kinsey Clarke (Black)	<u>ForHarriot.com</u>	2014	May 2017	Restriction
Erika Nicole Kendall (Black)	<u>Ebony.com</u>	February 25 th , 2013	May 2017	Binge Eating
Danielle Young (Black)	<u>Hellobeautiful.com</u>	October 2013	May 2017	Binge Eating
Jackie (White)	<u>MEDA Blog</u>	2013	May 2017	Restriction
Claudia Garza (Latina)	<u>CNN News</u>	March 26 th , 2010	May 2017	Restriction, Binge Eating /Purging
Clarissa H. Matthews (Black)	<u>Clutch Mag online</u>	2010	May 2017	Restriction
Chary Jay (Black)	<u>YouTube</u>	August 2 nd , 2010	June 2017	Restriction
Sue (White)	<u>MEDA Blog</u>	2010	May 2017	Binge Eating/Purging
Stephanie Covington Armstrong (Black)	Memoir— Not All Black Girls Know How to Eat: A Story of Bulimia	2009	May 2017	Restricting, Binge Eating/Purging
Jenni Schaefer (White)	Memoir – Life Without Ed: How One Woman Declared Independence from her Eating Disorder and How You Can Too	2003	May 2017	Restricting
Mary Guilbeault (White)	<u>NEDA Blog</u>	Unknown	May 2017	Binge Eating, Purging
Kate (White)	<u>MEDA Blog</u>	Unknown	May 2017	Restricting, Purging
Stephanie (White)	<u>MEDA Blog</u>	Unknown	May 2017	Restriction, Purging
Colleen (White)	<u>MEDA Blog</u>	Unknown	May 2017	Unspecified Eating Disorder Behaviors
Christina (White)	<u>MEDA Blog</u>	Unknown	May 2017	Restricting, Purging
Rachel (White)	<u>MEDA Blog</u>	Unknown	May 2017	Restricting

Identifying and Anonymizing Story Authorship

The first and last names of authors who wrote the stories used within this sample have been included only if the names were provided by women. The names of two women whose Instagram pages were used in this sample were kept anonymous and have been identified only by their race or ethnicity. The decision to anonymize these women's identities was based on the fact that these women may not have known that their content was publicly accessible on Instagram. Especially since the information shared by these women was sensitive, I chose not to use their names to ensure their privacy. Most women who published their stories on the Multi-Service Eating Disorders Association blog remained anonymous by publishing their stories only using their first names.

Selection of White Women's Stories

Due to the abundance of white women's stories on blogs, social media pages, and news I used random selection to determine which stories would be analyzed from an initial list of almost one-hundred stories. To further decrease the sample size of potential white women's stories, stories published only on the National Eating Disorders Association and the Multi-Service Eating Disorder Association blogs were compiled. From this list, stories were selected using systematic random sampling. White women's stories were taken only from these blogs and from published memoirs since these sources are abundantly cited and read. No YouTube videos, Instagram pages, or Podcast episodes were used for white women's stories. The fact that white women's stories were written in a more structured format was taken into consideration when comparing those stories to stories presented through alternative media forms. Stories were not coded based on length or structure, but according to references and themes that were mentioned by women. It is possible that the sample of white women's stories represents a sample of women with more "typical" ED experiences; however, the white women whose stories were chosen were diverse in geography (representing 11 U.S. States), age at publication of story, and eating disorder behaviors.

Potential Biases in Story Selection

The use of published stories may have led to bias within the stories related to women's personality type and amount of social support. The publication of a personal story means that the information within the story is available for all to read, outing the author to everyone with access to internet or social media and making the women vulnerable to feedback from anonymous online commenters. In many cases, this meant that the author needed support from their family and friends before publishing their stories, since those closest to them would have access to their publication and would most likely be the ones supporting them through the publication process. Only women who felt supported, emotionally stable, resilient, and able to cope well enough to tell their stories were able to be included in these analyses. Given the writing and technical skills required to share their stories in the sampled formats, it is likely that women in the sample meet a similar minimum threshold of education. These potential biases make it difficult to know how representative the story sample is when it comes to eating disorder experiences. However, the use of data collected from YouTube videos, Instagram pages, and blogs allowed for some women's stories to be told in a more casual, conversational, and non-academic format. The ability to use stories translated from Spanish to English within this sample allowed for many more Latina women's stories to be included, eliminating the need for women to be comfortable English speakers in order for their stories to be used in the study.

Search Words Used To Collect Stories

<u>Website Name</u>	<u>Search Words or Hashtags</u>
YouTube	Trastorno Alimenticio (<i>eating disorder</i>) Eating disorder story Black girl eating disorder Atracón de comida (<i>binge eating</i>)
Tumblr	Eating Disorder Anorexia Bulimia
Google	Latina eating disorders Black girls eating disorders Trastorno Alimenticio Eating disorders in Latina females
Instagram	#edrecovery #eatingdisorder #eatingdisorderproblems #eatingdisorderssuck #eatingdisorderawareness
Podcasts	Food Psych The Eating Disorder Podcast with Tabitha Farrar Let it Out with Katie Dalebout The Eating Disorder Recovery Podcast with Dr. Janean Anderson ED Matters

Clinician Interview Schedule

1. Could you describe the training/schooling you completed to become a clinician?
2. Why did you choose to work with people who have eating disorders? How much experience have you had working with clients with eating disorders?
3. Is there such thing as a “typical” eating disorder sufferer? If so, would you say that this differs based on the type of eating disorder a person is experiencing (anorexia vs. binge eating vs. bulimia)?
4. Did you ever receive training on “multiculturalism” or “diversity” within graduate school? How would you assess the quality of that training?
5. Within your training and practice, how would you describe the populations (in terms of race, ethnicity, social class, religion, etc.) you have worked with the most?
6. Do you incorporate aspects of racial or ethnic identity into treatment with your clients?
7. How do you think a person’s race/ethnicity impacts how they experience treatment for an eating disorder?
8. How do you think a Black or Latina woman may experience a mental illness such as an eating disorder differently than a white woman? Why?
9. How do you work to accommodate members of underserved populations struggling with mental health issues? How might you work to accommodate minority clients with eating disorders who you want to make feel more welcomed into your practice?

Additional questions added to interview schedule and asked to final three clinicians:

1. How many mentors or professors of color were you able to interact with in graduate school, or even during your undergraduate studies? How did those relationships impact your learning?
2. How have aspects of your personal identity impacted your practice?

Glossary of Key Terms

Acculturation: The process through which individuals begin to “adopt aspects of the dominant culture as a result of exposure” without leaving behind their native culture” (Molinary, 2007, p.2). Examples of acculturation include learning the dominant culture’s language and internalizing and acting upon the social norms of the dominant culture regarding concepts such as beauty, social interaction, and gender roles.

Assimilation: A process in which an individual “leaves behind their native culture in order to adapt to the new culture” (Molinary, 2007, p.3). This may refer to an individual who only speaks the new, dominant language and/or fails to incorporate aspects of their native culture into how they dress, speak, eat, and interact with others.

Binge/Compulsive Eating: The National Eating Disorders Association defines binge eating as “a severe, life-threatening and treatable ED characterized by recurrent episodes of eating large quantities of food (often very quickly and to the point of discomfort); a feeling of a loss of control during the binge; experiencing shame, distress or guilt afterwards; and not regularly using unhealthy compensatory measures (e.g., purging) to counter the binge eating.”

Black/African-American: Referring to anyone who identifies as having total or partial ancestry deriving from the continent of Africa. African-American or black-American are terms used specifically to refer to individuals of African descent living in the United States, while black is a racial identity that includes anyone who identifies with having African heritage. Individuals who identify racially as black can also identify as Latino/a, as well as define themselves in terms of any other ethnic group.

Body Image: The way an individual understands their physical body and appearance as part of their identity and environment.

Colonialism: From the perspective of the history of the United States, colonialism broadly refers to when Europeans stole Native American land in the 16th century. However, colonialism is an ongoing phenomenon, impacting the lives of thousands. The land currently referred to as encompassing the United States is stolen land, which must be acknowledged. Native American’s land continues to be colonized today, leaving native communities disenfranchised and powerless.

Culture-Bound Syndrome: A diagnosis which manifests itself most evidently in specific cultures, based on that culture’s stressors, ideals, or morals.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5): The academic text used to classify psychiatric diagnoses by doctors and clinicians in the United States, written and published by the American Psychiatric Association. The DSM has many editions, but is currently in its 5th edition which was published in 2013.

Disordered Eating: The DSM-5 defines disordered eating as “a wide-range of irregular eating behaviors that do not warrant a diagnosis of a specific ED.” This includes any behavior in which a person does not listen to their body’s hunger or fullness cues. Examples include the diet-binge cycle, being afraid of and avoiding “bad” foods, consciously but infrequently skipping meals to lose weight, and engaging in infrequent binge episodes.

Eating Disorder (ED): Eating Disorders (EDs) are serious but treatable mental illnesses in which individuals engage in unhealthy behaviors around food and the way that it impacts their bodies. Symptoms of EDs can be wide-ranging, and manifest both physically and psychologically. Official ED diagnoses include anorexia nervosa, bulimia nervosa, binge eating disorder, orthorexia, EDNOS/OSFED, pica, and diabulimia.

Eating Disorder Not Otherwise Specified(EDNOS)/Other Specified Feeding or Eating Disorder (OSFED):

The diagnosis of EDNOS was updated to OSFED in the DSM-5. Individuals diagnosed with OSFED do not fit into the diagnoses of EDs such as anorexia, bulimia, or binge eating, and may present with a mix of ED behaviors such as restriction, purging, or bingeing.

Embodiment: The individual experience of living in one's body and understanding how the body relates to socially constructed ideals related to health, beauty, and morality.

Epistemology: The theory of knowledge. It investigates "the standards used to assess knowledge or why we believe what we believe to be true" (Collins, 1990, p. 252).

Hispanic: "This word was first used by the U.S. Census Bureau in the late 1970s to identify people in the United States who have ancestral ties to Latin American countries, Spanish-speaking Caribbean nations, and Spain. Rather than identify a race, this term identifies a group unified through a commonality in culture and language" (Molinary, 2007, p.3). Not all individuals feel comfortable with being called "Hispanic," and I will use the term only if an individual referred to themselves as Hispanic.

Latino/a/x: "A person who is of Latin American heritage and lives in the United States. Many people of the younger generations prefer 'Latino' to 'Hispanic' as a label. It is not uncommon to see the bisected usage; 'Latino/Hispanic.'" (Molinary, 2007, p.4). The term refers to a diverse group of people, and is an ethnic rather than racial category. Individuals who identify as Latino could potentially racially identify as white, black, mestizo (mixed white/indigenous), Indigenous, or any other racial group. However, the majority of individuals who identify as Latino are multiracial (Pew Research Center, 2015). It is important to note that, although I refer to black and Latina women together as "women of color," not all Latina women identify as people of color. The term "Latino" refers not to a person's race, but to their ethnic and cultural identity as someone who grew up within a Latin American or Spanish-speaking culture. This can include women of European descent who grew up in Latin America, or mixed-race women who are white-passing. Although the term "Latina" does not necessarily tell us anything about a person's race, it does tell us that they do not identify as having been brought up with culturally American values. This means that although not all Latina women may present as having black or brown skin, all Latina women are connected in their identification with Latin American and Spanish-speaking cultures.

Medical-Industrial Complex: The network of corporations that supply healthcare services and products for profit (Relman, 1980).

Intersectionality: A term originally coined by legal and feminist scholar Kimberlé Crenshaw to describe how black women's intersecting identities lead them to experience oppression in a specifically nuanced way. Since its inception, the term has most commonly been used when referring to intersectional feminism, which addresses the intersecting forms of oppression that marginalized women experience due to not only their gender, but also their race, immigration status, body size, religion, sexual orientation, socioeconomic status, and other forms of identity-based prejudice.

In-patient/residential ED treatment: The most intensive level of care for an individual presenting with ED behaviors. Individuals live and receive treatment at a residential center with other individuals struggling with EDs. Residential treatment is usually necessary for those who are medically and psychiatrically unstable, and at risk for seriously hurting themselves (NEDA, 2017).

Marginalized: Individuals who are members of groups excluded due to race, ethnicity, religion, cultural group, age, ability, gender, immigration status, socioeconomic status, among other identifying factors.

Multiracial feminism: A term used by Becky Thompson to refer to a kind of intersectional feminism that recognizes the integration of racial issues within feminism. The term focuses on emphasizing that characterizations of women of color are “embedded in notions about white heterosexual women, and that it is impossible to understand [women of color] without” also understanding how they are understood in relation to white women (Thompson, 1996, p.16).

Out-patient ED treatment: A type of ED treatment recommended for an individual who is medically and psychiatrically stable, and can function in their daily lives (NEDA, 2017). This treatment is sometimes used by individuals seeking support in their recovery, and can include individual and/or family therapy, therapy groups, and other relapse prevention tools (Eating Recovery Center, 2017).

Purging: An ED behavior used to rid an individual of food or calories.

Restriction: An ED behavior in which an individual consciously does not eat enough to sustain themselves, which most commonly leads to weight loss or bingeing.

Slavery: Although the term slavery most commonly refers to the 300 years of chattel slavery in the United States, slavery is ongoing and present within institutions such as the prison industrial complex, which disproportionately enslaves black men and other people of color. The impact of the enslavement of not only black Americans, but also Native Americans, is still present and must be acknowledged as directly contributing to the social, medical, political, economic, and educational inequalities that exist in the United States today.

White: A racial classification used for individuals of predominantly European ancestry.

White feminism: Feminism that fails to account for intersectionality, thereby failing to incorporate the experiences of women of color or women/individuals with other marginalized identities. The term is rooted in the history of feminist movements that led and catered to the needs and experiences of white cisgender women only.

White-passing: A term used to describe the appearance of a mixed individual who looks white, or may be read as white by others who are not aware of their ancestry. This term is commonly used to describe women who possess ancestry is white, but also includes indigenous Latin American and/or African descent. The term has its roots in slavery when passing as white was especially advantageous.

Woman of Color: A woman who is not of predominantly white or European ancestry. (i.e. Asian, African, Latin American, Native American, or Pacific Islander). The term was first used as a way to include other minority women into black political activism in the 1970s (Ross, 2015).