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# Lived Experiences of Black, Indigenous, and People of Color (BIPOC) Counselors Collaborating With Multidisciplinary Teams to Treat BIPOC Clients Diagnosed With Eating Disorders

Melissa Sherfield  
*Walden University*

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# Walden University

College of Social and Behavioral Health

This is to certify that the doctoral dissertation by

Melissa LaFranz Sherfield

has been found to be complete and satisfactory in all respects,  
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the review committee have been made.

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Walden University  
2026

Abstract

Lived Experiences of Black, Indigenous, and People of Color (BIPOC) Counselors  
Collaborating With Multidisciplinary Teams to Treat BIPOC Clients Diagnosed With  
Eating Disorders

by

Melissa LaFranz Sherfield

MA, Richmond Graduate University, 2018

BS, University of Phoenix, 2014

Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy  
Counselor Education and Supervision

Walden University

May 2026

## Abstract

Eating disorder (ED) treatment has historically been grounded in Eurocentric models that inadequately account for the cultural contexts and lived experiences of Black, Indigenous, and people of color (BIPOC), contributing to persistent disparities in care. The purpose of this descriptive transcendental phenomenological study was to explore the lived experiences of BIPOC counselors who provide culturally responsive care to BIPOC clients diagnosed with EDs. Guided by Husserl's phenomenological philosophy of intentionality and Giorgi's descriptive phenomenological method, the central research question addressed the lived experiences of BIPOC counselors providing culturally responsive ED care, with a sub-question addressing how counselors describe their preparedness to provide such care. Semistructured interviews were conducted with six licensed BIPOC counselors working in ED treatment settings, and data were analyzed using Giorgi's five-step analytic procedure. Five essential themes emerged: (a) lack of education and training and the need for structural and educational change, (b) diagnosis prioritized over personhood, (c) marginalization in predominantly White spaces, (d) advocacy as emotional and professional risk, and (e) cultural responsiveness as individual responsibility. Subthemes included nontraditional entry into the ED field, learning through immersion, the need for structural and educational change, and reflexivity and unlearning cultural conditioning. Implications for positive social change include strengthening counselor education, organizational policy, and ED treatment practices to support structurally embedded culturally responsive care and more equitable services for BIPOC communities.

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## Dedication

This dissertation is dedicated to anyone who has ever felt they are not good enough, not capable enough, or unable to achieve the goals set before them. Let this work serve as proof that you can succeed when you persevere.

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First, I want to acknowledge my mother, Angela, affectionately known as Ma. You have taught me the true meaning of perseverance through the way you raised your children. You pushed and fought to make sure we had what we needed. Because of you, I know what hard work looks like, and I know what not giving up looks like. That foundation has shaped who I am, and I deeply appreciate your hard work, love, and dedication to your children.

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## Table of Contents

List of Tables .....	vi
Chapter 1: Introduction to the Study.....	1
Background.....	2
Problem Statement.....	4
Purpose.....	5
Research Questions.....	6
Theoretical Framework.....	6
Nature of the Study .....	7
Definitions.....	8
Assumptions.....	9
Scope and Delimitations .....	10
Limitations .....	12
Significance.....	13
Summary.....	15
Chapter 2: Literature Review.....	17
Literature Search Strategy.....	18
Theoretical Foundation .....	19
Previous Application in Research.....	20
Rationale for Descriptive Method.....	21
Key Concepts .....	22
Education and Training.....	22

BIPOC Counselors in the ED Field .....	28
Collaborating on Multidisciplinary Teams .....	31
Treating BIPOC Clients With EDs .....	35
Culturally Responsive Care .....	38
Summary and Conclusions .....	41
Chapter 3: Research Method.....	43
Research Design and Rationale .....	44
Research Question .....	44
Central Phenomenon.....	44
Research Tradition and Rationale.....	45
Role of the Researcher .....	46
Positionality .....	47
Ethical Considerations .....	47
Methodology.....	49
Participant Selection .....	49
Sample Size and Inclusion Criteria.....	50
Exclusion Criteria .....	50
Procedures for Recruitment .....	51
Instrumentation .....	51
Data Analysis Plan.....	52
Issues of Trustworthiness.....	55
Credibility .....	55

Transferability.....	55
Dependability.....	56
Confirmability.....	56
Ethical Procedures .....	57
Summary.....	59
Chapter 4: Results.....	61
Virtual Setting.....	62
Demographics .....	63
Data Collection .....	64
Sample Size.....	65
Semistructured Interview .....	65
Memos.....	66
Data Analysis .....	67
Step 1: Reading Each Full Transcript in Its Entirety .....	67
Step 2: Adopting a Phenomenological Reduction Stance.....	68
Step 3: Dividing the Transcripts Into Meaning Units.....	68
Step 4: Transforming Each Meaning Unit Into Themes.....	69
Step 5: Synthesizing and Structuring the Results .....	70
Discrepant Cases and Variations .....	73
Evidence of Trustworthiness.....	74
Credibility .....	74
Transferability.....	75

Dependability .....	76
Confirmability.....	76
Results of the Study .....	77
Emergent Themes .....	79
Theme 1: Lack of Education and Training and the Need for Structural and Educational Change .....	80
Theme 2: Diagnosis Prioritized Over Personhood.....	91
Theme 3: Marginalization in Predominantly White Spaces .....	94
Theme 4: Advocacy as Emotional and Professional Risk .....	97
Theme 5: Cultural Responsiveness as Individual Responsibility.....	99
Subtheme 5a: Reflexivity and Unlearning Cultural Conditioning.....	102
Results Synthesis .....	105
Discrepant Cases.....	107
Summary.....	107
Chapter 5: Discussion, Conclusions, and Recommendations.....	109
Interpretation of the Findings.....	110
Summary of Key Findings .....	112
Interpreting Findings Within the Theoretical Foundation .....	113
Theme 1: Lack of Education and Training and the Need for Structural and Educational Change .....	113
Theme 2: Diagnosis Prioritized Over Personhood.....	120
Theme 3: Marginalization in Predominantly White Spaces .....	122

Theme 4: Advocacy as Emotional and Professional Risk .....	124
Theme 5: Cultural Responsiveness as Individual Responsibility .....	126
Synthesis of Interpretation .....	130
Limitations of the Study.....	131
Credibility Limitations.....	131
Transferability Limitations .....	132
Dependability Limitations .....	133
Confirmability Limitations .....	134
Summary of Limitations .....	134
Recommendations.....	135
Implications.....	136
Implications at the Individual Level .....	136
Implications at the Family Level .....	137
Implications at the Organizational Level.....	138
Societal and Policy Implications.....	139
Methodological, Theoretical, and Empirical Implications .....	140
Conclusion .....	140
References.....	142
Appendix A: Interview Guide.....	157
Appendix B: Email Invitation.....	159
Appendix C: Resources for Participants .....	160

List of Tables

Table 1. Participants' Demographic Data.....	64
Table 2. Themes Developed Using Giorgi's Descriptive Phenomenological Method.....	72
Table 3. Cross-Participant Matrix of Essential Themes .....	79

## Chapter 1: Introduction to the Study

Over the past few decades, researchers in the eating disorder (ED) field have had to reassess their understanding of the illness's etiology and those it affects to provide effective treatment (Mazzeo, 1999; Munroe, 2022). In the early 2000s, researchers recognized an increase in diagnoses among men (Alexander, 1998; Quinn & Robinson, 2020) and soon after identified a growing prevalence rate among diverse ethnic and cultural groups (Labarta et al., 2023; Levitt, 2006). As the diversity among individuals seeking treatment continues to grow and the number of Black, Indigenous, and other people of color (BIPOC) counselors in the workforce increases, there is a heightened need for culturally responsive care (Biang et al., 2024). Researchers suggested that counselor education programs may be insufficient in preparing counselors to effectively serve BIPOC clients (Labarta et al., 2023; Levitt, 2006). The current study explored the understanding of experiences of BIPOC counselors working in the ED field and contributed to the existing literature to enhance the effectiveness of counselors in treating individuals affected by the illness.

In this chapter, I provide an overview of the recent literature on the preparedness of BIPOC counselors working in the field of EDs and their collaboration with multidisciplinary teams in treating BIPOC clients. I discuss the limited research available on this topic, as well as the overall lack of education and training for counselors in this area. Chapter 1 includes the problem statement, purpose statement, research questions, and theoretical framework. Additionally, I provide an overview of the nature of the study

and significance, emphasizing the role of BIPOC counselors collaborating on multidisciplinary teams providing culturally responsive care to BIPOC clients with EDs.

### **Background**

EDs are severe and life-threatening illnesses affecting approximately 28.8 million people across the United States and contributing to around 10,000 deaths each year (Goel et al., 2022; Irvine & Labarta, 2024; National Eating Disorders Association [NEDA], 2022a). The counseling profession acknowledges the outdated myth that EDs only impact skinny, White, affluent girls (Biang et al., 2024; Halbeisen et al., 2022; Sonnevile & Lipson, 2018), and counselors are increasingly recognizing that EDs affect individuals across all ages, genders, races, and ethnicities (Acle et al., 2021; Halbeisen et al., 2022); socioeconomic statuses; religions (NEDA, 2022a); sexual orientations; and abilities (Armour et al., 2024; Burk et al., 2023; Small & Fuller, 2021). As the field of EDs becomes increasingly diverse in both clients and counselors, there remains a lack of research on BIPOC counselors and clients (Biang et al., 2024; Halsbeisen et al., 2022; Uri et al., 2021). However, the current body of literature still lags in addressing culturally responsive care to this population (Biang et al., 2024; Jennings-Mathis et al., 2020; Labarta & Bendit, 2024).

A review of the literature highlighted a gap in research regarding the experiences of BIPOC counselors in the field, as well as providing culturally responsive care to BIPOC clients (Kazdin et al., 2017; Labarta et al., 2023; Sonnevile & Lipson, 2018). Studies indicated that counselor education programs offer little to no education on this subject, contributing to counselors' lack of confidence, ineffective treatment approaches,

and insufficient preparation for multidisciplinary collaboration (Bray et al., 2023; Labarta et al., 2023). Although the recent research has examined various related topics, such as the experiences of counselors of color, their work in the ED field (Biang et al., 2024); the limited education and training on EDs (Labarta et al., 2023; Levitt 2006); the significance of multidisciplinary collaboration (Bray et al., 2025; Klein & Beeson, 2022; Woodruff et al., 2020); and the need for culturally responsive care (Kanakam, 2022; Labarta & Bendit, 2024), there was a gap in the literature addressing these concepts as a whole.

Despite growing attention to diversity in counseling, the field remains predominantly homogenous, with 73% of counselors identifying as White (Jennings-Mathis et al., 2020). This demographic imbalance highlights a significant gap in the literature regarding the experiences of BIPOC counselors, both within counselor education programs and in clinical practice (Biang et al., 2024; Irvine & Labarta, 2024). Although there is an ongoing effort to promote culturally responsive care, much of the existing research centered on White counselors' perspectives, leaving the voices of BIPOC counselors underrepresented (Halbeisen et al., 2022; Labarta & Bendit, 2024). Additionally, studies exploring counselors' roles on multidisciplinary teams often lack diverse representation, overlooking the unique intersectional experiences of BIPOC counselors bring to these collaborative settings (Klein & Beeson, 2022). Together, these gaps underscored the need for research that centered on BIPOC counselors' experiences and perspectives across educational, clinical, and team-based contexts.

## **Problem Statement**

Researchers have found that EDs are difficult illnesses to treat, often leading counselors to experience exhaustion, burnout, and high client relapse rates (Goel et al., 2022). Over 90% of counselors will encounter a client diagnosed with an ED at some point in their careers (Harrop et al., 2023; Thompson-Brenner et al., 2012). However, many counselors and professionals in the field feel inadequately trained and lack confidence in their ability to effectively treat this population (Graham et al., 2020; Labarta et al., 2023). The lack of education and clinical training provided in counselor education programs contributes to ineffective treatment, poor collaboration among multidisciplinary team members, and potential ethical concerns in practices regarding cultural competency (Bray et al., 2023; Labarta et al., 2023).

Previous research on counselors' lived experiences of working in the ED field primarily examined the perspectives of White, cisgender women, highlighting what they believe is needed to improve (Irvine & Labarta, 2024). As the ED workforce becomes more diverse, with an increasing number of BIPOC counselors (Jennings-Mathis et al., 2020); they often face additional challenges, including microaggressions, biases, and feelings of isolation in a predominately White profession (Biang et al., 2024; Jennings-Mathis et al., 2020; Halbeisen et al., 2022). Few studies have focused on the experiences of counselors of color working in the ED field, particularly regarding their experiences collaborating with multidisciplinary teams to provide culturally responsive care for BIPOC clients in White spaces. Gaining a deeper understanding of BIPOC counselors' experiences collaborating with multidisciplinary team members on BIPOC clients may

offer valuable insight into how to support them in the field, enhance evidence-based treatments that promote cultural competency, and drive systemic change within the ED profession. Without this critical information, counselor educators may not be fully equipped to prepare future counselors to treat clients with EDs, collaborate effectively with multidisciplinary teams in supporting BIPOC clients, and provide culturally responsive care.

### **Purpose**

The purpose of this descriptive phenomenological qualitative study was to explore and describe the lived experiences of BIPOC counselors regarding their preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs, particularly within the context of multidisciplinary treatment teams. Although there has been a growing call to action to diversify the counseling workforce and enhance training on culturally responsive care (Goel et al., 2022; Halbeisen et al., 2022; Jennings-Mathis et al., 2020; Labarta et al., 2023); existing literature has not adequately explored how BIPOC counselors experience collaboration within multidisciplinary teams or how they navigate systemic and interpersonal dynamics within these team settings (Bray et al., 2025; Woodruff et al., 2020). The current study addressed a gap in the recent literature, which primarily focused on the experiences of White and BIPOC counselors treating predominately White clients with EDs (Biang et al., 2024; Labarta et al., 2023), often neglecting the unique perspectives of BIPOC counselors working with BIPOC clients within multidisciplinary team settings.

### **Research Questions**

What are the lived experiences of BIPOC counselors who collaborate with multidisciplinary teams providing culturally responsive care to BIPOC clients diagnosed with eating disorders?

Subquestion: How do BIPOC counselors describe their level of preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs as part of a multidisciplinary treatment team?

### **Theoretical Framework**

The theoretical framework for this study was transcendental phenomenology, rooted in the philosophical works of Husserl (1962), to capture knowledge from a first-person point of view, focusing on the lived experiences of BIPOC counselors (see Peoples, 2021). At the core of Husserl's philosophy lies an emphasis on capturing the essence of lived experiences through full engagement with the phenomenon as it appears to consciousness (Giorgi, 2009; Peoples, 2021). Additional core principles of Husserl's philosophy including intentionality, signifying the intrinsic orientation of consciousness toward an object or phenomenon (Giorgi, 2009; Peoples, 2021); epoche, or bracketing, which involves the suspension of prior judgements and assumptions (Giorgi, 2009; Peoples, 2021); and phenomenological reduction, a systematic analytic process wherein the researcher closely examines the meaning structures embedded within participants' lived experiences (Peoples, 2021).

The use of a transcendental phenomenological approach allowed me to authentically capture the lived experiences of BIPOC counselors in the ED field by

setting aside my personal assumptions and focusing their narratives throughout Giorgi's (2009) analytic process. This method allowed me to identify the essence of participants' experiences, revealing underlying meaning structures that transcended individual accounts while preserving the rich contextual nuances within each narrative (see Giorgi, 2009; Peoples, 2021). The research questions guiding this study were designed to elicit detailed first-person narratives of how BIPOC counselors navigate their professional roles and engage in collaboration with multidisciplinary teams within predominantly White ED settings. These questions aligned with Giorgi's analytic process to focus on intentionality, meaning making, and lived experiences (see Peoples, 2021).

### **Nature of the Study**

To answer the research questions in this qualitative study, I employed a descriptive phenomenological approach. This approach emphasized capturing knowledge from the first-person perspectives (see Husserl, 1962) of BIPOC counselors, exploring how they describe their preparedness in treating clients with EDs, collaborating within multidisciplinary teams, and delivering culturally responsive care to BIPOC clients (see Giorgi, 2009). By focusing on lived experiences, the phenomenological approach was well suited for highlighting BIPOC counselors' descriptions of their readiness in the field.

The participant population consisted of BIPOC counselors who currently work or had previously worked in the ED field for a minimum of 1 year. I recruited participants using purposive and snowball sampling. Purposive sampling allowed for the intentional selection of participants who met specific criteria and possessed the lived experience of

the phenomenon under study (see Patton, 2015). This sampling method facilitated the collection of rich, contextually detailed insights from individuals who had experience with the phenomenon (see Ravitch & Carl, 2021). To qualify for participation in the study, individuals were required to meet the inclusion criteria: (a) identify as a person of color, (b) be 21 years or older, (c) hold a minimum of a master's degree in clinical mental health, (d) be fully licensed as an independent counselor, (e) have experience working within a multidisciplinary team treating the same client, and (f) provide direct counseling services to BIPOC clients with EDs.

I conducted in-depth, semistructured interviews to capture the participants' lived experiences in treating BIPOC clients diagnosed with EDs and collaborating with multidisciplinary teams to provide culturally responsive care. I used open-ended questions to encourage participants to share their stories, capturing their attitudes, experiences, and behaviors related to working in the ED field (see Creswell & Creswell, 2023; Patton, 2015). For the data analysis, I followed Giorgi's (2009) five steps of data analysis process, which included reading the entire transcripts, assuming an attitude of phenomenological reduction, breaking down transcripts into meaning units, transforming the meaning units into phenomenologically psychologically informed descriptions, and organizing the results (see Shelton & Bridges, 2019).

### **Definitions**

The following terms are defined to enhance understanding of the concepts of ED terminology:

*BIPOC clients* are individuals from racially and ethnically marginalized communities who often face unique challenges in accessing ED treatment, such as misdiagnosis, underrepresentation in research, and lack of culturally competent care (Biang et al., 2024; Halbeisen et al., 2022; Labarta & Bendit, 2024).

*BIPOC counselors* in the ED field are mental health professionals who identify as BIPOC and contribute their unique lived experiences and cultural insight to their clinical work (Labarta & Bendit, 2024).

*Culturally responsive care* involves integrating cultural awareness, humility, and relevance into treatment practices, acknowledging clients' sociocultural contexts and utilizing frameworks such as relational-cultural therapy and self-compassion to address systemic barriers and promote client empowerment (Jacquart et al., 2024; Labarta & Bendit, 2024).

*Multidisciplinary teams* in ED treatment consist of professionals from various disciplines such as counseling, psychiatry, nutrition, and medicine who work collaboratively to provide integrative, patient-centered care (Labarta et al., 2023; Maia et al., 2024).

### **Assumptions**

For the current study, I assumed that BIPOC counselors working in the ED field could reflect on and describe their lived experiences of collaborating within multidisciplinary teams and striving to provide culturally responsive care. I also assumed that participants would engage authentically and fully in the interview process, offering rich descriptions of their experiences appropriate for phenomenological analysis (see

Giorgi et al., 2017; Patton, 2015). These assumptions were important to the meaningfulness of the study because transcendental phenomenology relies on participants' ability to convey the essence of their experiences (Neubauer et al., 2019) without the researcher imposing external interpretations or personal assumptions (see Ravitch & Carl, 2021). These assumptions were important because transcendental phenomenology focuses on the intentionality of consciousness, which is the principle that individuals are capable of meaningfully describing their experiences as they perceive them (Neubauer et al., 2019). Although I engaged in the process of epoche to bracket personal biases, I assumed that participants lived experiences would be both rich and communicable, providing the foundation for a rigorous phenomenological inquiry (see Ravitch & Carl, 2021).

### **Scope and Delimitations**

In the current study, I specifically focused on exploring the lived experiences of BIPOC counselors who collaborated with multidisciplinary teams to provide culturally responsive care to BIPOC clients diagnosed with EDs. I intentionally decided to narrow the focus on BIPOC counselors, guided by existing literature indicating that professional experiences within the ED field are influenced by the intersections of racial identity and systemic factors. Rather than examining the general experiences of all counselors in the ED field, I focused on the perspectives of BIPOC counselors, whose voices have been historically underrepresented (see Biang et al., 2024; Halbeisen et al., 2022; Labarta & Bendit, 2024). I also explored how they experience multidisciplinary collaboration within this specialized field. By using a transcendental phenomenological approach, I captured

and described the essence of these experiences as conveyed by the participants themselves, without imposing pre-existing theoretical interpretations (see Peoples, 2021; Ravich & Carl, 2021).

The study is delimited to BIPOC counselors who are currently or have previously worked in ED treatment settings. Counselors who do not identify as BIPOC were intentionally excluded to focus on the experiences that are uniquely shaped by racial and cultural identity within a predominantly White profession (Biang et al., 2024; Irvine & Labarta, 2024). Additionally, only counselors with experience in multidisciplinary collaboration were included, while those whose roles were solely independent or non-collaborative were excluded. To stay in alignment with a transcendental phenomenological approach, I did not apply or assess broader theoretical frameworks, such as Critical Race Theory (CRT). I instead focused on the participants' descriptions of their lived experiences, allowing themes to emerge naturally from the data (see Patton, 2015).

Transferability is limited to contexts with similar characteristics, such as specialized mental health settings where BIPOC professionals are underrepresented or where multidisciplinary collaboration is important to care. Although universal generalizability is not the objective, I provided rich, thick descriptions to allow readers to evaluate the relevance of the findings to their own settings (see Burkholder et al., 2020). Through this approach, I offered meaningful insights for clinical supervisors and educators dedicated to promoting more inclusive and culturally responsive treatment environments within the ED field.

## **Limitations**

This qualitative descriptive phenomenological study presented several limitations. One key limitation was transferability; given the study's focus on BIPOC counselors within ED treatment settings in the US, the findings may not extend to counselors in other countries, disciplines, or cultural contexts (see Creswell & Poth, 2018; Moustakas, 1994). Additionally, although efforts were made to recruit a diverse sample across racial and ethnic backgrounds, the relatively small, selected sample typical of phenomenological research may not fully represent the full range of experiences across all BIPOC groups (see Patton, 2015). Another limitation involved dependability, as the study relies on participants' self-reported experiences, which may be affected by memory recall, personal interpretation, or comfort level during interviews (see Creswell & Poth, 2018). Despite the use of structured interview protocols and consistent data analysis procedures, some degree of variability remains unavoidable.

An additional limitation associated with transcendental phenomenology is the need for the researcher to set aside personal biases, attitudes, beliefs, and assumptions to capture the true essence of participants' experiences (Neubauer et al., 2019; Peoples, 2021). Researcher bias was a particular concern in this study, as I am the sole researcher conducting the investigation. To address this, I engaged intentionally in bracketing and reflexive practices, including the use of reflexive journals and documented my analytic decisions, to suspend personal perspectives and remain focused on the participants' lived experiences. Additionally, peer debriefing was incorporated throughout the research

process to critically examine and validate interpretations, enhancing the study's credibility and reducing the influence of individual bias (see Burkholder et al., 2020).

Given the relatively small and interconnected nature of the ED field compared to other counseling specialties, there was also a risk that participants may recognize one another if too much identifying information is disclosed. To mitigate this risk, I took careful and intentional steps to protect participants' identities, including the use of generalized descriptions, omitting potentially identifying details, and assigning each participant a pseudonym. Additionally, ensuring trustworthiness of the study, specifically credibility, dependability, and confirmability, is essential for the rigor of the study. Credibility, or the extent to which the findings are believable are based on the data presented (see Burkholder et al., 2020), was enhanced through strategies such as member checking, persistent observation, peer debriefing with a qualified colleague not involved in the study. Maintaining detailed reflexive journals served as ongoing checks throughout the data collection and analysis process. Although the findings may not be broadly generalizable, the insights gained were intended to deepen understanding of an unexplored phenomenon and contribute to the advancement of culturally responsive interventions within multidisciplinary treatment teams.

### **Significance**

In the current study, I contributed meaningfully to the academic world on culturally responsive counseling practices within the specialized field of ED treatment. Specifically, I addressed a significant gap in the literature by focusing on the lived experiences of BIPOC counselors who collaborated within multidisciplinary teams.

Although previous research has largely focused on clinical outcomes, access to care, or generalized cultural training (Sonnevile & Lipson, 2018); limited attention has been given to the first-person perspectives of BIPOC counselors working in predominately White treatment environments (Cheng et al., 2019; Jennings-Mathis et al., 2020; Thompson-Burdine, 2021). Even fewer have explored how these counselors experience multidisciplinary collaboration and the complexities of providing culturally responsive care within these environments (Woodruff et al., 2024). Using a transcendental phenomenological approach, I suspended my assumptions through bracketing to focus on the essence of the participants lived experiences (see Neubauer et al., 2019). The findings of this study were intended to inform future research by providing insight into the intersection of identity and professional practice in ways that have not been examined before in the ED field.

The current study is significant because it provided insight into the unique experiences of BIPOC counselors working in the ED field and treating BIPOC clients. As the population of individuals affected by EDs becomes increasingly diverse, it is important for both the counseling workforce and treatment interventions to incorporate culturally responsive practices (Biang et al., 2021; Jennings-Mathis et al., 2020; Labarta & Bendit, 2024). Addressing these needs requires an intentional focus on how BIPOC counselors experience the treatment environment, particularly within multidisciplinary team settings. The current study also has the potential to initiate critical conversations about systemic change in the field. More specifically, the findings of this study may support the development of culturally responsive training curricula within counselor

education programs, ensuring that counselors-in-training are better prepared to effectively treat individuals with EDs while addressing the specific cultural needs of BIPOC clients (see Labarta et al., 2023).

There is potential for positive social change, and are closely aligned with the study's scope and objectives. By focusing on the voices and lived experiences of BIPOC counselors and highlighting their lived realities, I hope to contribute to the efforts to dismantle systemic inequities and challenge the dominant paradigm that has historically excluded or marginalized diverse perspectives within the ED field (Goode et al., 2019; Halbeisen et al., 2022). Enhancing cultural responsiveness and increasing workforce diversity could lead to improved therapeutic engagement, reduce disparities in care, and promote more healing for historically underserved populations (Halbeisen et al., 2022; Jennings-Mathis et al., 2020). This study supported the contributions to BIPOC counselors and a vision of systemic change that strengthens the inclusivity and effectiveness of the ED field. Ultimately, in the current study, I contributed to the advancement of scholarly knowledge, enhanced culturally responsive care, and promoted positive social change by focusing on the lived experiences of BIPOC counselors within multidisciplinary treatment team settings.

### **Summary**

In the current study, I filled a critical gap in the ED field by exploring the lived experiences of BIPOC counselors who provided culturally responsive care to BIPOC clients within multidisciplinary teams. Despite the growing number of EDs among diverse populations, both research and counselor education programs have lagged in

addressing the needs of BIPOC clients and in equipping BIPOC counselors for effective care (Halbeisen et al., 2022; Jennings-Mathis et al., 2020). Much of the existing literature focuses on the experiences of White counselors, often overlooking the systemic challenges BIPOC counselors face (Biang et al., 2024; Labarta et al., 2023), including inadequate training, marginalization, and underrepresentation within collaborative care settings (Halbeisen et al., 2022).

Guided by transcendental phenomenology, I explored how BIPOC counselors described their professional preparedness, collaborative roles in ED treatment, and their ability to provide culturally responsive care to BIPOC clients. The findings are intended to enhance counselor education programs, inform inclusive clinical practice, and support systemic changes in multidisciplinary team-based settings for BIPOC clients. In Chapter 2, I reviewed the existing literature related to counselor preparedness, the representation of BIPOC counselors in the ED field, multidisciplinary collaboration, BIPOC clients diagnosed with EDs, and culturally responsive care. This review highlighted current knowledge, identified gaps, and provided the theoretical framework for this study.

## Chapter 2: Literature Review

Despite the growing occurrence of EDs among diverse populations (Labarta et al., 2023; Sonnevile & Lipson, 2018), counselor education programs and clinical frameworks have not evolved to adequately prepare counselors, particularly BIPOC counselors, to provide culturally responsive care (Biang et al., 2024; Labarta & Bendit, 2024). Previous research exploring counselors' experiences in the ED field has largely centered on the perspectives of White, cisgender women, often emphasizing their views on needed improvements within the profession (Irvine & Labarta, 2024). However, as the field becomes increasingly diverse, BIPOC counselors frequently encounter unique challenges, including microaggressions, systemic bias, and professional isolation within predominantly White settings (Biang et al., 2024; Halbeisen et al., 2020; Jennings-Mathis et al., 2020).

Despite this shift, limited scholarly attention has been given to the experiences of BIPOC counselors, especially in relation to their roles on multidisciplinary teams and their efforts to provide culturally responsive care to BIPOC clients in settings historically shaped by White norms. The lived experiences of BIPOC counselors, particularly regarding their perceived preparedness to provide culturally responsive care within multidisciplinary treatment teams, were explored and highlighted in the current descriptive phenomenological study. In this chapter, I review previous research on key topics, such as EDs, counselor education training programs, BIPOC counselors' perceived readiness to treat clients, collaboration within multidisciplinary teams, and competency in providing culturally responsive care to BIPOC clients.

### Literature Search Strategy

For the literature search, I used multiple methods to find peer-reviewed articles, including meeting with a librarian to ensure I used every method available for a comprehensive search. The primary databases used included APA PsycInfo, Academic Search Complete, Academic Search Index, Complementary Index, Education Source, MEDLINE, and CINAHL Plus. The keywords I used for the search were *counselors of color, therapists of color, Latin\* counselors, Latin\* therapists, Hispanic counselors, Hispanic therapists, African American counselors, African American therapists, Black counselors, Black therapists, Indigenous counselors, Indigenous therapists, Asian counselors, Asian therapists, minority counselors, minority therapists, preparedness, readiness, training, higher education, university, college, graduate programs, master programs, eating disorder workforce, disordered eating, eating disorders, anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, integrative team, multidisciplinary team, interdisciplinary team, interprofessional team, healthcare team, African American patients, African American clients, Black patients, Black clients, Latin\* patients, Latin\* clients, Hispanic patients, Hispanic clients, Asian patients, Asian clients, Indigenous patients, Indigenous clients, Black, Indigenous, and other people of color (BIPOC) patients, culturally responsive treatment, multicultural training, multicultural interventions, and racial/ethnic matching.*

Additionally, I conducted searches using Google Scholar search engine, Walden University's dissertation and thesis database, ProQuest, and other scholarly books. I also explored other research studies using qualitative, phenomenological, and transcendental

approaches to aid in the review process. These sources helped deepen my understanding of phenomenological methodologies and informed the analytical approach used in this study.

### **Theoretical Foundation**

In the current study, I utilized the descriptive phenomenological method developed by Giorgi (2009), which is grounded in the philosophical foundations of Edmund Husserl's transcendental phenomenology (see Husserl, 1962; Peoples, 2021). Phenomenology was originally developed by Husserl, who is recognized as the "father" of phenomenological philosophy (Peoples, 2021). He promoted that research should have a presuppositionless approach, which means researchers are required to examine the phenomenon independently of any pre-existing theoretical frameworks or assumptions (Giorgi, 2009; Husserl, 1962; Peoples, 2021). At the core of Husserl's philosophy, the focus is on describing the essences of lived experiences by engaging fully with the phenomenon as it presents itself to consciousness (Giorgi, 2009; Peoples, 2021).

Another core principle of Husserl's philosophy is the concept of intentionality, which refers to the inherent directedness of consciousness toward objects or phenomena (Giorgi, 2009; Peoples, 2021). Within the context of this study, intentionality relates to the ways in which BIPOC counselors are aware of both their professional roles and cultural experiences within the ED field. Additionally, Husserl introduced the process of epoche, or bracketing as a methodological approach to suspend prior judgments and assumptions (Giorgi, 2009; Peoples, 2021). This allows for the examination of the phenomenon as it is subjectively experienced and described by the participants (see

Peoples, 2021). Another fundamental component is phenomenological reduction, which is a systematic analytic process that is followed by bracketing, in which the researcher attends closely to the meaning structures embedded within the participants' narratives (Giorgi, 2009). This process enables the identification of the essence that characterizes the phenomenon being studied (Peoples, 2021). Husserl also elaborated on the concepts of noema, the object or content of thought, and noesis, the act of thinking (Giorgi, 2009; Peoples, 2021). Both illustrate the intentional relationship between subject and object within consciousness (Peoples, 2021).

Building upon Husserl's philosophical foundations, Giorgi (2009) transformed phenomenology into a systematic methodology applicable to research investigating psychological phenomena. Giorgi emphasized that phenomenological research in psychology should remain descriptive, focusing on the collection of rich, first-person accounts of lived experiences without engaging in interpretation or theoretical analysis (Peoples, 2021). Through a rigorous process of data analysis, Giorgi's method allows for the identification of essential meaning structures that transcend individual accounts while remaining firmly anchored in the participants lived experiences (Giorgi, 2009).

### **Previous Application in Research**

Although there is limited existing research that directly applies Giorgi's method to the experiences of BIPOC counselors within the ED field, phenomenological approaches have been effectively applied to examine marginalized voices within healthcare professions (see Altman et al., 2020). For example, descriptive phenomenology has been employed to investigate the experiences of minority clinicians

as they navigate systemic racism, cultural incongruence, and institutional power structures within healthcare and mental health settings (Altman et al., 2020; Henriksen et al., 2020). In these studies, researchers highlighted the importance of valuing participants lived experiences to inform understanding, rather than imposing predetermined theoretical frameworks that may fail to adequately capture their distinct positionalities (Giorgi, 2009; Peoples, 2021).

### **Rationale for Descriptive Method**

Choosing Giorgi's descriptive phenomenological method for this study was grounded in its alignment with this study's primary objective to authentically capture the lived experiences of BIPOC counselors within the ED field. This approach enabled implementation of bracketing, which allowed me to suspend personal assumptions related to race, cultural identity, and professional practice, thereby focusing on the participants lived experiences throughout the analytic process (see Giorgi, 2009; Peoples, 2021). Additionally, the focus on identifying the essence of the participants' experiences offered the identification of underlying meaning structures that extend beyond individual accounts while preserving the rich, contextual nuances present within each narrative (see Giorgi, 2009). This approach was well-suited to address the complexities of systemic inequities, intersectionality, and cultural identity that characterize the professional experiences of BIPOC counselors in the ED field.

The central research question and subquestion that guided this study are designed to elicit rich, first-person accounts of how BIPOC counselors experienced their professional roles, navigated systemic and cultural challenges, and engaged in

collaboration with multidisciplinary teams within predominantly White ED treatment settings (Biang et al., 2024; Peoples, 2021). These questions are methodologically aligned with phenomenology's emphasis on intentionality, meaning making, and lived experiences (see Giorgi, 2009). Rather than testing predetermined hypotheses or conducting comparative analyses, I explored how participants construct meaning around their professional roles and cultural identities in the ED field (see Peoples, 2021). In doing so, the research questions supported a process of discovery that remains grounded in the participants' subjective lived experiences. This generated findings that contributed to the development of culturally responsive practices, informed professional training, and supported systemic reform within the ED field.

### **Key Concepts**

#### **Education and Training**

Counselor education programs provide a critical foundation for entry into the mental health profession, equipping future counselors with the theoretical knowledge, ethical principles, and practical skills necessary for the profession (Irvine et al., 2021; Jacquart et al., 2024). However, in specialized areas such as ED treatment, there is increasing concern that graduate-level training remains insufficient in these programs (Labarta et al., 2023; Levitt, 2006). Despite the growing prevalence and complexity of EDs among diverse populations, most counseling curricula lack required coursework or supervised clinical experiences specific to EDs (Irvine et al., 2021; Labarta et al., 2023; Levitt et al., 2006). This educational gap can pose as a hindrance to counselors' overall preparedness to provide effective care and poses additional challenges for BIPOC

counselors, who must navigate systemic barriers in accessing culturally responsive, ED-specific training (Biang et al., 2024).

### ***Inadequate Preparation in Counselor Education Programs***

A growing body of literature highlights critical deficiencies in the training and preparation of counselors to effectively treat EDs, particularly within counseling education programs (Biang et al., 2024; Irvine & Labarta, 2024; Labarta et al., 2023). These gaps present barriers for all counselors entering the field, but they are especially pronounced for BIPOC counselors, who must navigate additional challenges rooted in systemic inequities in access, representation, and inclusion (Halbeisen et al., 2022; Jennings-Mathis et al., 2020). Without adequate preparation and support, these barriers may limit BIPOC counselors' opportunities to enter and remain in specialized treatment settings such as ED care.

Labarta et al. (2023) conducted a national survey of 109 interdisciplinary clinicians, including counselors, psychologists, and social workers, and found that 60% of participants reported feeling unprepared to treat EDs due to insufficient graduate-level training. Only 25.7% of participants had access to a course specifically focused on EDs, and 73% received five hours or less of related instruction. Similarly, Biang et al. (2024) reported that participants consistently described a lack of education and training during their graduate programs. As a result, many counselors pursued additional training independently once in the field, often feeling overwhelmed as they attempted to integrate this knowledge into their clinical work. These findings mirror broader concerns about the

lack of standardized, comprehensive education in this specialty across counselor education programs (Irvine & Labarta, 2024; Labarta et al., 2023).

Although Labarta et al. (2023), did not exclusively examine BIPOC counselors, it highlighted systemic issues that disproportionately impact marginalized communities. The findings hold relevance for both BIPOC counselors and the treatment of BIPOC clients (Labarta et al., 2023). In the study, clinicians cited the absence of culturally responsive care and the prevalence of weight stigma as significant challenges within ED treatment environments (Kerl-McClain et al., 2022; Perez et al., 2021; Uri et al., 2021). Additionally, the qualitative data emphasized the importance of integrating educational and social justice frameworks such as body size diversity, increased awareness of diet culture, and fatphobia to support diverse populations more effectively (Labarta et al., 2023).

### ***Barriers BIPOC Counselors Face in Training***

The challenges highlighted in these studies are particularly intensified for BIPOC counselors, who are frequently discouraged from pursuing ED-specific practicum or internship placements and are often left to independently pursue specialized training after graduation (Biang et al., 2024; Jennings-Mathis et al., 2020). Biang et al. (2024) found that many counselors, especially those from marginalized backgrounds, felt their graduate programs inadequately prepared them to treat EDs (Jennings-Mathis et al., 2020), particularly in the context of serving racially diverse populations. Few were supported in seeking ED-specific education during their training, leading them to rely on self-directed

continuing education well into their careers to develop necessary competencies (Biang et al., 2024; Jennings-Mathis et al., 2020; Lertora et al., 2020).

Although Biang et al. (2024) did not focus exclusively on BIPOC counselors, they revealed systemic shortcomings within ED treatment environments. These shortcomings disproportionately impacted underrepresented counselors, including a lack of culturally responsive instruction and the persistence of White normative standards in ED treatment environments (Shell et al., 2022; Smith et al., 2021). These barriers illustrate broader structural inequities within counselor education programs that contribute to the ongoing underrepresentation and marginalization of BIPOC counselors in specialized areas of care (Halbeisen et al., 2022; Jennings-Mathis et al., 2020).

### ***Inadequate Cultural Frameworks and Social Justice in Training***

Qualitative findings from Biang et al. (2024) highlighted a significant deficit in the integration of social justice frameworks within counselor education programs. This exposed a disconnect between stated multicultural values and practical implementation (Lertora et al., 2020). Expanding on this concern, Labarta et al. (2023) emphasized the critical need to integrate cultural norms related to body size, anti-diet cultural principles, and fat phobia awareness into the counseling curricula (Labarta et al., 2023; Kerl-McClain et al., 2022). Such integration is essential to equip future counselors with the competencies required to provide culturally responsive care to diverse populations.

Shell et al. (2022) conducted a study involving 252 licensed Black clinicians, including counselors, psychologists, marriage and family therapists, and social workers. Researchers explored the impact of cultural racism and professional workload on burnout

symptoms (Miu & Moore, 2021; Yang & Hayes, 2020). Their findings indicated that Black therapists frequently encountered race-related stress and vicarious racism when working with Black clients and other clients of color, increasing the emotional stress of their clinical work further contributing to burnout. Therefore, Shell et al. (2022) similarly argued that counselor education programs must progress beyond superficial multicultural inclusion and actively engage in decolonizing clinical training. They advocated for the adoption of frameworks like the Multicultural and Social Justice Counseling Competencies (MSJCC), which require an intentional interrogation of power, privilege, and systemic oppression in counseling practice (Ratts et al., 2016; Singh et al., 2020).

Reinforcing this perspective, Smith et al. (2021) found that despite stated commitments to anti-racism, many training programs continue to uphold Eurocentric standards and White-centered pedagogies (Shell et al., 2022), further marginalizing BIPOC trainees. Smith et al. (2022) revealed that 78% of BIPOC counseling students experienced racial invalidation during their graduate training (Smith et al., 2021). Without a good foundation in critical multicultural and social justice approaches, counselor education programs risk perpetuating clinical harm, particularly through the failure to recognize non-stereotypical ED presentations or by reinforcing dominant norms that exclude and alienate BIPOC clients.

### ***Improving Counselor Education Training Programs***

In response to these gaps in counselor training and retention, scholars have proposed developmental frameworks designed to foster professional growth and support, particularly for counselors from marginalized backgrounds (Irvine & Labarta, 2024).

Irvine et al. (2021) introduced the Deliberate Practice Coaching Framework (DPCF), which integrates peer mentoring and reflective supervision as core components of counselor preparation. This model provides a culturally responsive foundation that may be especially beneficial for BIPOC trainees and counselors pursuing roles in the ED field. Central to the DPCF is its emphasis on culturally attuned mentorship, particularly through guidance from doctoral-level supervisors to reduce performance anxiety, enhance self-efficacy, and support long-term retention of BIPOC counselors in specialized care settings (Hipolito-Delgado et al., 2021; Irvine et al., 2021). Beyond cultivating individual clinical competence, the framework aims to challenge systemic inequities by affirming diverse therapeutic identities and expanding accepted modalities of care (Goel et al., 2022; Irvine et al., 2021).

The consequences of inadequate training extend beyond individual counselor development and have direct implications for equitable access to culturally affirming ED care (Sonneville & Lipson, 2018). BIPOC clients are disproportionately at risk of being misdiagnosed, underdiagnosed, or excluded from treatment due to culturally limited diagnostic criteria and a lack of racial and ethnic representation within multidisciplinary treatment teams (Small & Fuller, 2021; Sonneville & Lipson, 2018). In the absence of substantial reform in counselor education programs, these disparities are likely to persist, reinforcing patterns of mistrust and disengagement among marginalized populations (Kerl-McClain et al., 2022; Labarta et al., 2023).

Providing comprehensive training, supervision, and resources, particularly for BIPOC counselors, is not only essential for enhancing clinical effectiveness but also

represents a critical step toward advancing justice and inclusion in the field (Goel et al., 2022; Singh et al., 2020). The limited research focused on ED-specific training within counselor education highlights a pressing need for systemic change. Programs must broaden their curricula to include ED treatment while integrating culturally responsive, anti-oppressive frameworks that acknowledge and address the lived experiences of diverse communities (Kerl-McClain et al., 2022). This need is particularly urgent in the light of the unique challenges and contributions of BIPOC counselors, whose perspectives remain underrepresented in conventional educational models (Irvine & Labarta, 2024). Focusing on these voices and addressing structural inequities is vital for fostering equity in both counselor preparation and client care.

### **BIPOC Counselors in the ED Field**

The ED field has historically been influenced by White, Western, and biomedical frameworks (Brooks-Ucheaga, 2023; Kazdin et al., 2017; Smith et al., 2021); however, there is increasing acknowledgment of the need for greater racial and ethnic diversity among counselors providing care. Despite increasing rates of EDs among racial and ethnic diverse populations, BIPOC counselors remain underrepresented in these settings (Halbeisen et al., 2022; Jennings-Mathis et al., 2020). This disparity reflects not only systemic barriers within counselor education programs and limited access to specialized training (Biang et al, 2024; Labarta et al., 2023) but also points to deeper structural inequities embedded in the mental health profession (Halbeisen et al., 2022). BIPOC counselors who do enter the field often face distinct challenges, including professional isolation, lack of mentorship, cultural tokenism, and limited opportunities for

advancement (Biang et al., 2024; Jennings-Mathis et al., 2020). Nevertheless, their inclusion is vital, not only for advancing culturally responsive care for marginalized populations, but also for challenging dominant treatment models that have historically overlooked or misrepresented the experiences of BIPOC individuals (Kazdin et al., 2017).

### *Experiences of Marginalization*

BIPOC counselors working in the ED field often navigate environments marked by racial tokenism, emotional labor, and insufficient institutional support (Biang et al., 2024; Bommen et al., 2023). In Biang et al.'s (2024) study, researchers conducted interviews with 10 counselors of color (COC) and identified consistent themes of marginalization and professional isolation. Participants described being expected to educate their predominantly White colleagues on cultural issues and serve as “racial bridges” (p. 484) for clients of color, often without formal recognition or support (Biang et al., 2024). These expectations contributed to emotional exhaustion and, for many, a sense of questioning their professional belonging.

Similarly, Choe et al. (2024) found that 68% of BIPOC counselors surveyed felt unprepared to manage racial microaggressions from their White clients during therapy sessions. Despite frequent encounters with racial bias, most reported receiving little to no training or institutional guidance on how to address these dynamics, leading to compromised therapeutic alliances and an increased risk of burnout (Goel et al., 2022). BIPOC counselors are more likely than their White counterparts to be questioned about

their competency, prompting them to engage in behaviors such as excessive credential disclosure or adopting more formal stances during sessions (Choe et al., 2024).

In a study by Brooks-Ucheaga (2023), participants emphasized the emotional toll of racism on their personal well-being and professional roles. Participants also described the complexity of establishing therapeutic trust with racially similar clients, and the lack of guidance in conceptualizing racism within standard treatment protocols. In the study, Brooks-Ucheaga (2023) criticized the Eurocentric framework of current psychotherapeutic models and called for the development of culturally competent interventions. These findings align with broader literature that documents how BIPOC counselors face systemic barriers related to emotional safety within predominantly White professional settings, clinical supervision, and career advancement (Jennings-Mathis et al., 2020; Singh et al., 2020). In ED contexts, these challenges may be intensified by the cultural Whiteness embedded in dominant treatment models, including normative assumptions about body image, food rituals, and recovery trajectories (Labarta et al., 2023). BIPOC counselors are often required to adapt or challenge these frameworks to provide care that is responsive to the lived experiences of their clients (Choe et al., 2024).

### ***Connection Through Cultural Identities***

Despite these systemic challenges, BIPOC counselors continue to demonstrate insight and relational strength (Hamilton, 2024). Many draw upon cultural similarity with clients to foster a deeper therapeutic connection. Biang et al. (2024) emphasized an “unspoken connection” (p. 486) between BIPOC counselors and clients of color, with 80% of participants identifying the relational dynamic as grounded in shared cultural

understanding, language, and identity. Similarly, Hamilton (2024) found that Black therapists reported stronger rapport and a heightened sense of emotional safety when working with Black clients, which contributed to increased client engagement and improved therapeutic outcomes.

### ***Exclusion From Research and Leadership***

Outside the therapeutic setting, BIPOC counselors frequently face exclusion from research participation, leadership pathways, and workforce development initiatives within the ED field (Biang et al., 2024; Halbeisen et al., 2022; Jennings-Mathis et al., 2020). Strauch et al. (2023) found that 78% of ED clinical trials do not meet basic standards for racial and ethnic diversity, thereby perpetuating Eurocentric treatment models and marginalizing BIPOC perspectives in both clinical practice and decision-making roles. In addition, recruitment efforts often lack culturally responsive strategies, further restricting BIPOC professionals' access to roles within specialized ED treatment settings (Jennings-Mathis et al., 2020; Strauch et al., 2023).

### **Collaborating on Multidisciplinary Teams**

Effective treatment for EDs typically involves a multidisciplinary team approach, drawing on the combined expertise of counselors, dietitians, physicians, psychiatrists, and other allied health professionals to provide comprehensive, patient-centered care (Crest et al., 2024; Horn et al., 2024; Hrovat et al., 2013; Maia et al., 2024; Zanskas et al., 2022). Within these teams, collaboration is essential for addressing the complex medical, psychological, and nutritional needs of individuals with EDs. However, the effectiveness of this collaboration can be impacted by power dynamics, professional hierarchies, and

implicit biases, factors that frequently place BIPOC counselors at a disadvantage (Horn et al., 2024; Klein & Beeson, 2022; Maia et al., 2024). While multidisciplinary teams are intended to promote holistic care, research suggests that BIPOC counselors may experience marginalization, exclusion from decision-making processes, or a devaluation of their cultural insights and clinical contributions within these team structures (Choe et al., 2024; Klein & Beeson, 2022; Ng et al., 2023). Therefore, exploring how BIPOC counselors navigate their roles within these collaborative frameworks is essential to understanding both the possibilities for inclusive care and the systemic barriers that persist in ED treatment settings.

### ***Complexity and Promise of Multidisciplinary Care***

Multidisciplinary collaboration is foundational to effective ED treatment, bringing together the specialized knowledge of counselors, dietitians, physicians, psychiatrists, and other professionals. When this collaborative model is grounded in mutual respect, clear communication, and well-defined roles, it has been shown to enhance treatment outcomes (Choe et al., 2024; Crest et al., 2024; Horn et al., 2024). For example, Bray et al. (2024) reported a 17% increase in treatment adherence among adolescents when teams operated with clearly delineated roles and mutual respect. In contrast, when collaboration was marked by power imbalances and microaggressions, conditions that often marginalize BIPOC counselors, there was a 24% increase in early treatment dropout, disproportionately affecting BIPOC clients (Bray et al., 2024).

Woodruff et al. (2020) highlighted the advantages of coordinated care, finding that patients engaged in integrated multidisciplinary treatment were 2.6 times more likely

to achieve weight restoration compared to those treated in fragmented or hospital-based systems. However, despite these positive outcomes, BIPOC counselors often face systemic obstacles within team environments, such as restricted access to leadership positions and insufficient acknowledgment of their expertise (Bray et al., 2024). These barriers can hinder effective collaboration and compromise the equitable delivery of care.

### ***Marginalization Among BIPOC Counselors***

A range of systemic challenges encountered by BIPOC counselors within multidisciplinary team environments is evident, including experiences of marginalization, unclear role expectations, and a disproportionate burden of racialized labor (Choe et al., 2024). In a study conducted by Zanskas et al. (2022), 62% of BIPOC clinicians surveyed across interprofessional settings reported feeling marginalized during case consultations, noting that their clinical input was often minimized, redirected, or disregarded. Although race did not yield statistically significant results in the pre-posttest of overall team satisfaction, the authors highlighted existing literature that points to persistent structural barriers hindering BIPOC counselors' ability to assert clinical authority (Zanskas et al., 2022). Similarly, Choe et al. (2024) found that BIPOC clinicians were 1.8 times more likely than their White counterparts to be informally tasked with diversity-related responsibilities, such as educating colleagues on racial dynamics or mediating cultural conflicts, often without formal recognition or compensation. These additional responsibilities intensify emotional labor, detract from core clinical functions, and contribute to professional exhaustion.

Such experiences are frequently shaped by implicit hierarchies that prioritize medical authority over psychosocial and culturally responsive approaches (Zanskas et al., 2022). Within ED treatment settings, such hierarchies can diminish the visibility and perceived value of BIPOC counselors' clinical contributions, especially those grounded in relational, anti-oppressive, or culturally responsive frameworks (Geller et al., 2023). As a result, BIPOC counselors may face constraints in advocating for culturally responsive interventions and experience limited influence in collaborative treatment planning. Ng et al. (2023) noted that similar systemic challenges extend globally, where counseling is often undervalued as a discipline within international ED care systems that are largely governed by Western biomedical models.

### ***Moving Toward Inclusive Team-Based Practice***

The effectiveness of multidisciplinary collaboration is interconnected with clinician well-being and the degree of organizational support provided (Choe et al., 2024; Zanskas et al., 2022). Geller et al. (2023) found that clinicians exhibiting higher levels of self-compassion demonstrated a 40% increase in collaborative engagement. In contrast, Bommen et al. (2023) reported that ED organizations lacking equity-oriented support systems experienced a 35% higher rate of staff turnover within two years. These findings highlight the importance of cultivating environments that promote safety, cultural humility, and emotional sustainability.

Fostering these environments requires a deliberate restructuring of team dynamics, supervisory practices, and leadership models to uphold shared responsibility, inclusiveness, and equity (Maia et al., 2024; Zanskas et al., 2022). Culturally inclusive

and equality-centered collaboration must be recognized as an essential standard for providing affirming care to BIPOC clients. Multidisciplinary teams that adopt culturally responsive frameworks, acknowledge the unique expertise of all disciplines, and actively confront systemic biases are better equipped to meet the needs of diverse populations (Zanskas et al., 2022). In support of this, Bray et al. (2024) found that teams grounded in cultural humility achieved 19% higher client satisfaction rates, demonstrating the critical link between inclusive team dynamics and positive treatment outcomes. Ultimately, establishing collaborative, inclusive ED teams requires sustained organizational commitment to mentorship, leadership development, and structural equity (Maia et al., 2024; Zanskas et al., 2022). This is particularly important for ensuring that the voices and insights of BIPOC counselors are not only included but central to providing meaningful transformation within the ED field.

### **Treating BIPOC Clients With EDs**

Although there is growing awareness that EDs impact people of all racial and ethnic backgrounds, BIPOC clients still face systemic inequities throughout the treatment process (Biang et al., 2024; Burke et al., 2021; Halbeisen et al., 2022). These disparities, ranging from misdiagnosis and under-recognition to inadequate access to culturally competent care. Such challenges are rooted in Eurocentric frameworks that have predominately focused on the experiences of White, cisgender, thin, and affluent populations (Biang et al., 2024; Halbeisen et al., 2022; Jennings-Mathis et al., 2020). As a result, BIPOC clients are less likely to receive an accurate and timely diagnosis, face greater cultural and structural barriers to accessing care, and experience worse treatment

outcomes (Cheng et al., 2019; Small & Fuller, 2021). Sonnevile and Lipson (2018) found that 17% of BIPOC college students with clinically significant ED symptoms received a formal diagnosis, compared to 38% of White students, highlighting significant disparities in detection (Gordon et al., 2023). These gaps are further intensified by providers' implicit bias, which often associates EDs with thin, White, affluent women, leading to the underdiagnosis or misdiagnosis of BIPOC individuals (Gordon et al., 2023; Sonnevile & Lipson, 2018).

The narrow diagnostic criteria governing ED assessments are subject to increasing scrutiny in recent research (Egbert et al., 2022; Halbeisen et al., 2022). In a study of over 900 participants, Perez et al. (2021) found that purging behaviors were prevalent among BIPOC women, even when traditional "shape concerns" (p. 754), often central to existing diagnostic criteria, were not present. Similarly, Uri et al. (2021) reported that 14% of Asian American college students engaged in purging, 27% in muscle-building behaviors, and 30% in cognitive restraint, challenging the stereotype that EDs are primarily driven by a desire for thinness. The need for culturally responsive diagnostic assessment tools capable of capturing the full spectrum of symptom presentations across diverse populations is indicated by these findings (Perez et al., 2021; Uri et al., 2021).

### ***Barriers to Access of Treatment***

Even when EDs are accurately diagnosed, BIPOC clients often face systemic obstacles that hinder their ability to engage in and sustain treatment (Small & Fuller, 2021; Sonnevile & Lipson, 2018). Factors such as cultural stigma, fear of discrimination, language barriers, and financial concerns frequently discourage individuals from

initiating or continuing care (Chen & Gonzales, 2022; Egbert et al., 2022; Perez et al., 2021). Reyes-Rodriguez et al. (2013) found that 64% of Latina women with EDs postponed treatment due to stigma and the lack of culturally responsive services. However, findings in a follow-up study indicated that culturally adapted, family-based interventions increased treatment retention by 21%, highlighting the effectiveness of aligning care with clients' cultural values and family structures (Acle et al., 2021; Fleming et al., 2021; Reyes-Rodriguez et al., 2019).

The therapeutic alliance is also a key component of engagement in treatment. Cheng et al. (2023) reported a 35% increase in therapeutic alliance scores when clients were matched with racially or ethnically concordant therapists in long-term care settings. Similarly, Hamilton (2024) found that such concordance led to a 30% increase in clients reported emotional safety. The researcher highlighted how cultural matching can foster trust, lessen internalized shame, and promote sustained treatment engagement where secrecy, ambivalence, and emotional vulnerability are often central barriers to progress (Hamilton, 2024).

### ***Need for Systemic Reform***

Meeting the treatment needs of BIPOC clients with EDs calls for a systemic transformation of both clinical practices and institutional frameworks. Strauch et al. (2023) reported that 78% of ED clinical trials failed to meet minimal standards for racial and ethnic diversity. This raises concerns about the applicability of these interventions to marginalized populations (Strauch et al., 2023; Williams-Ridgway et al., 2025). The underrepresentation not only limits the evidence base for culturally responsive care but

also reinforces exclusion across policy, funding, and clinical innovation (Strauch et al., 2023).

Addressing the needs of BIPOC clients requires more than improving individual cultural competence; it requires structural shifts in diagnostic frameworks, training programs, research methodologies, and organizational cultures (Labart et al., 2023; Ratts et al., 2016). Key priorities include developing culturally grounded assessment tools, increasing access to racially diverse providers, and investing in community-led prevention and treatment strategies (Goel et al., 2022; Halbeisen et al., 2022). Without these systemic changes, BIPOC individuals will remain vulnerable to misdiagnosis, limited access, and poorer outcomes in ED care (Goel et al., 2022).

### **Culturally Responsive Care**

Culturally responsive care is increasingly recognized as both a clinical and an ethical obligation in ED treatment, particularly in addressing inequities faced by marginalized populations (Lertora et al., 2020). Researchers predominately developed and validated conventional treatment models, such as Cognitive Behavioral Therapy-Enhanced (CBT-E), using homogenous samples of White, cisgender, affluent individuals, which limits the applicability of these models across diverse communities (Kanakam, 2022; O'Donnell & Meloncelli, 2023; Sonnevile & Lipson, 2018). As a result, these approaches often overlook cultural norms, lived experiences, and sociopolitical realities of BIPOC clients, contributing to misdiagnosis, treatment disengagement, and suboptimal long-term outcomes (Goel et al., 2022; Halbeisen et al., 2022).

Perez et al. (2021) found that 28% of clinically significant ED cases were missed among BIPOC individuals due to non-fat-phobic symptom presentations and culturally distinct expressions of distress, highlighting the inadequacies of standard diagnostic criteria. In contrast, culturally responsive models emphasize identity-affirming, relational, and community-centered care. For example, Labarta and Bendit (2024) found that incorporating relational cultural theory alongside self-compassion practices led to a 25% increase in therapeutic alliance and an 18% decrease in internalized weight stigma over a 12-week period. Relational cultural theory's emphasis on mutual empathy, relational resilience, and cultural attunement makes it particularly relevant for BIPOC clients navigating the effects of systemic oppression (Jordan, 2018; Labarta & Bendit, 2024; Lertora et al., 2020). Similarly, Scharff et al. (2024) and Hamilton (2024) highlighted how culturally adapted CBT and narrative therapy, integrated with identity-affirming language and metaphors, can enhance emotional resilience and deepen engagement in therapy by 30%. Culturally responsive treatment also requires re-examining dominant health and beauty norms rooted in traditional care. Practices that pathologize culturally rooted values, such as larger body ideals, collective eating traditions, or spiritual understandings of wellness, risk continuing harm and cultural erasure if not carefully and respectfully adapted (Kerl-McClain et al., 2022).

### ***Counselor Self-Reflection and Supervision***

Providing culturally responsive care also requires a foundation of counselor self-awareness and a willingness to critically examine systemic and institutional norms (Labarta & Bendit, 2024; Labarta et al., 2025). Shell et al. (2022) emphasized that

decolonizing counseling practices involves conducting deliberate power analyses and challenging White-dominant treatment frameworks. Researchers found that Black therapists who received race-conscious supervision reported a 22% decrease in burnout symptoms compared to those in traditional supervisory settings. Similarly, Brooks-Ucheaga (2023) observed a 17% improvement in emotional well-being among Black counselors engaged in identity-affirming peer consultation groups.

Shell et al. (2022) suggested that counselor training programs must go beyond surface-level diversity initiatives to create lasting change. Smith et al. (2021) argued that dismantling Eurocentric frameworks within counselor education requires the integration of critical pedagogy, racial justice, and systemic advocacy into the curriculum. Without these structural shifts, counselors risk continuing the very inequities they seek to eliminate in their clinical work.

Halbeisen et al. (2022) and Goel et al. (2022) emphasized the importance of clinical research, noting that studies with at least 30% BIPOC participation produce findings that are more generalizable and culturally relevant than studies with more homogenous participants. Key policy initiatives include diversifying leadership pipelines, broadening clinical trial inclusion, integrating anti-racist principles within treatment models, and eliminating access barriers such as geographic isolation, financial issues, and language barriers (Halbeisen et al., 2022; Puhl, 2025). These changes are critical given the prevalent dominance of White-centered perspectives in clinical guidelines, research funding, and institutional leadership (Smith et al., 2021). Without intentional efforts to

correct these imbalances, culturally responsive treatment will remain marginalized despite its proven effectiveness.

### **Summary and Conclusions**

The current literature reveals significant gaps in counselor education programs when it comes to preparing BIPOC counselors to deliver ED treatment that is both clinically effective and culturally responsive. Although EDs affect individuals across racial and ethnic groups (Labarta et al., 2023; Sonnevile & Lipson, 2018), most counseling curricula lack required coursework or supervised experiences in ED-specific care (Irvine et al., 2021; Labarta et al., 2023). This lack of training disproportionately impacts BIPOC counselors, who must also navigate systemic barriers such as racial isolation, cultural tokenism, and limited access to mentorship (Biang et al., 2024; Jennings-Mathis et al., 2020). Additionally, dominant ED treatment models continue to rely on Eurocentric, biomedical frameworks that do not reflect the cultural contexts or lived experiences of BIPOC clients (Kazdin et al., 2017; Halbeisen et al., 2022).

Despite increasing acknowledgement of the importance of culturally responsive treatment, BIPOC counselors frequently report professional isolation, racialized labor, and microaggressions within predominantly White clinical settings and multidisciplinary teams (Biang et al., 2024; Choe et al., 2024; Halbeisen et al., 2022). Existing research has predominantly examined the perspectives of White counselors, omitting how BIPOC counselors engage in culturally responsive care within environments shaped by White norms (Irvine & Labarta, 2024). This omission limits the field's understanding of how systemic inequities are experienced and addressed by BIPOC counselors. Additionally,

little is known about how counselor education programs can be restructured to meaningfully to support BIPOC trainees in entering ED treatment settings (Biang et al., 2024; Shell et al., 2022; Smith et al., 2021).

This chapter provided an in-depth review of the literature on counselor education and training related to EDs, experiences of BIPOC counselors in the ED field, multidisciplinary collaboration, treatment approaches for BIPOC clients, and the implementation of culturally responsive care. Although a significant amount of research highlighted the disproportionate barriers BIPOC counselors face within the counseling profession and BIPOC clients with ED treatment, there remains a notable gap in the literature specifically addressing the lived experiences of BIPOC counselors working in the field. By focusing on the voices of BIPOC counselors, this study provided critical insight to inform counselor education programs, clinical supervision, and organizational policies to better prepare counselors to provide culturally responsive care to diverse populations. In Chapter 3, I discussed the methodology, theoretical framework, participant selections, and data collection.

### Chapter 3: Research Method

The purpose of this descriptive transcendental qualitative study was to explore and describe the lived experiences of BIPOC counselors who provide culturally responsive care to BIPOC clients diagnosed with EDs within multidisciplinary treatment teams. Due to the historical dominance of White, Western-centric models in ED treatment (Shell et al., 2022), the perspectives and contributions of BIPOC counselors had been largely underrepresented in research and insufficiently addressed in counselor education programs. In the current study, I addressed that gap by focusing on the voices of BIPOC counselors, exploring their level of preparedness, collaboration, and cultural responsiveness in treating racially diverse populations.

In this chapter, I describe the methodological approach for this study. I identify the research design and explain its rationale, highlighting the alignment of transcendental phenomenology with the goal of capturing the pure essence that the participants experience (see Peoples, 2021). I also describe the research questions and central phenomenon, followed by a detailed explanation of the research tradition and my role as the researcher, including reflexivity and positionality. Ethical considerations and issues related to conducting research with marginalized populations are discussed. The methodology section details the participant selection criteria, recruitment procedures, instrumentation, and data collection process. The data analysis plan is explained using Giorgi's (2009) five-step descriptive phenomenological method. Finally, strategies to ensure trustworthiness (credibility, transferability, dependability, and confirmability) are

described alongside ethical procedures to safeguard participant confidentiality, autonomy, and emotional well-being.

## **Research Design and Rationale**

### **Research Question**

What are the lived experiences of BIPOC counselors who collaborate with multidisciplinary teams providing culturally responsive care to BIPOC clients diagnosed with eating disorders?

Subquestion: How do BIPOC counselors perceive their level of preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs as part of a multidisciplinary treatment team?

### **Central Phenomenon**

The central phenomenon of this study was the descriptions of the lived experiences of BIPOC counselors working in the ED field, with a specific focus on their level of preparedness and challenges they encountered when collaborating within multidisciplinary teams to provide culturally responsive care to BIPOC clients. According to Biang et al. (2024), counselors of color often face additional challenges, including microaggressions, implicit biases, and feelings of isolation, as opposed to their White counterparts. There remains a significant gap in the literature concerning the experiences of BIPOC counselors in this context (Biang et al., 2024; Jennings-Mathis et al., 2020). This lack of research has resulted in limited guidance on culturally responsive interventions, effective team collaboration, and coping strategies for addressing race-related challenges. To address this gap, I employed a descriptive transcendental

phenomenological approach to explore and gain a deeper understanding of the lived experiences of BIPOC counselors working in the ED field.

### **Research Tradition and Rationale**

Qualitative research is inherently focused on gaining a deeper understanding of human experience as it relates to a phenomenon (Patton, 2015). Specifically, transcendental phenomenology emphasizes the focus of participants' voices and meaning making while intentionally minimizing the researcher's interpretation (Neubaur et al., 2019). This approach is important when exploring underrepresented or marginalized narratives that are at risk of being misinterpreted or overshadowed by dominant perspectives.

Transcendental phenomenology was especially well-suited for this study, as it explored and described the lived experiences of BIPOC counselors working within the ED field and collaborating with multidisciplinary teams. This approach enabled the participants' experiences to be described apart from my own assumptions, which encouraged a more authentic and unfiltered description of their realities. This process, known as bracketing, supported the aim of focusing participants' narratives that have been overlooked or misrepresented within dominant places (see Brooks-Ucheaga, 2023; Peoples, 2021). Given the historical marginalization of BIPOC voices in the ED field (Biang et al., 2024), the use of transcendental phenomenology is both an ethical and methodologically appropriate choice.

### **Role of the Researcher**

As the researcher, I functioned as the primary instrument of inquiry and maintained ongoing awareness of my identity and positionality throughout the research process (see Ravitch & Carl, 2021). This process involved continuously examining and reevaluating my underlying assumptions and positional stance in relation to the study (see Ravitch & Carl, 2021). Within a descriptive qualitative research approach, it is essential to deliberately suspend personal biases and approach the research with openness, as though possessing no prior knowledge of the subject (Peoples, 2021). To support this process, I maintained a reflexive journal to acknowledge, monitor, and critically reflect on any biases or preconceived judgments that emerged during the study.

Given that the field of EDs is a specialized area within mental health, it is relatively small; therefore, it is possible that other professionals could recognize participants. For this reason, I exercised great care to avoid disclosing any identifying information that could reveal participants' identities to others. I informed participants that the purpose of the interview was to provide them with an opportunity to share their lived experiences working in the ED field. Discussing experiences related to race and culture could be inherently challenging, and participants may have modified or filtered their responses more favorably to the researcher (see Burkholder et al., 2020; Ravitch & Carl, 2021). If any facial expressions or body language suggested that a participant was experiencing discomfort or was not responding authentically, I documented these observations in a memo after each interview.

**Positionality**

As the researcher for this study, I brought both personal and professional perspectives to my work with BIPOC counselors in the ED field. I am a Black, licensed professional counselor with more than seven years of clinical experience specializing in the ED field, where I have worked closely with multidisciplinary teams and supported BIPOC clients diagnosed with EDs. My interest in exploring the lived experiences of fellow BIPOC counselors is rooted in both my professional background and my personal commitment to advancing knowledge in this area of study.

Through my graduate education and professional experience in this specialized field, I became increasingly aware of the limited education and training available to counselor's treating individuals with EDs, particularly in addressing the needs of BIPOC clients through culturally responsive care. I also recognized a significant gap in the literature regarding BIPOC counselors working within this field and the importance of understanding their experiences to improve both the quality of care and broader systemic practices. I acknowledged the potential power differentials that may exist in my roles as a Black counselor, researcher, and doctoral candidate. To mitigate potential bias and maintain the integrity of the research process, I engaged in ongoing self-reflection through strategies such as reflexive journaling, self-evaluations, peer debriefing, and member checking.

**Ethical Considerations**

Although there is an increasing recognition of diversity within the ED field, the importance of ethical research practices that prioritize the safety, respect, and

empowerment of marginalized populations has often been overlooked (Biang et al., 2024; Jennings-Mathis et al., 2020; Labarta & Bendit, 2024). BIPOC counselors working in this field remain underrepresented in both clinical practice and scholarly research (Halbeisen et al., 2022). Therefore, it is essential to address ethical and safety considerations to protect the integrity of research involving BIPOC counselors (ACA, 2014, §A.6.a) and to honor their lived experiences within a predominantly White professional environment (Brooks-Ucheaga, 2023). To support these efforts, I informed participants that they could end the interview at any time and used open-ended questions to allow them the freedom to share only what they felt comfortable disclosing (Jefferson, 2024; Rubin & Rubin, 2011).

### ***Marginalized Populations***

Historical research involving marginalized communities has often been marked by misrepresentation, exploitation, and the denial of participant autonomy, contributing to deepened mistrust and ongoing marginalization (Alpers, 2016). BIPOC individuals also experience greater racial disparities both in society and within professional environments compared to their White counterparts (Scharff et al., 2024). Given documented experiences of BIPOC counselors facing microaggressions, isolation, and systemic barriers within predominantly White institutions (Biang et al., 2024; Brooks-Ucheaga, 2023; Halbeisen et al., 2022), it was important for me to adopt a culturally responsive approach that aligned with the ACA's standards for cultural sensitivity (A.2.c and E.5.b). I developed interview questions (see Appendix A) with careful attention to cultural contexts and the intersectionality of participants' identities. I also refrained from

making assumptions about participants' experiences and intentionally fostered an environment that encouraged genuine and authentic sharing of their narratives.

### ***Safety***

Prioritizing the avoidance of harm is essential when conducting research with participants and aligns with the ACA Standard A.6.a (ACA, 2014). While the individuals in this study are professionals, discussing their experiences with bias, racism, exclusion, or marginalization within the ED field may evoke heightened emotions (see Biang et al., 2024). To minimize potential harm, I reminded participants that they could decline to answer questions that caused emotional distress or discomfort and could withdraw from the study at any time without consequence. Additionally, I provided a hotline phone number and other support resources (see Appendix C) that participants could access upon request if they experienced emotional distress.

## **Methodology**

### **Participant Selection**

The target population for this research study consisted of fully licensed BIPOC counselors who were currently working or had previously worked in the ED field as members of a multidisciplinary treatment team for a minimum of one year. I recruited participants using purposive and snowball sampling methods. Purposive sampling allows for the intentional selection of individuals who meet specific inclusion criteria and possess the lived experience relevant to the phenomenon under investigation (see Patton, 2015). This approach facilitated the collection of rich, in-depth data grounded in participants' lived experiences (Ravitch & Carl, 2021). Snowball sampling was also

employed to expand the participant pool by allowing participants or other professionals to refer eligible counselors who may have been interested in participating in the study (see Ravitch & Carl, 2021).

### **Sample Size and Inclusion Criteria**

There is no predetermined or universally required number of participants required for qualitative research (Patton, 2015). However, I recruited between 6-10 participants to ensure that the sample would be sufficient to reach data saturation. I recruited participants via email (see Appendix B) and through an invitation flyer distributed to the International Association for Eating Disorder Professionals (IAEDP), the Academy of Eating Disorders (AED), relevant social media platforms, and Listservs. To be eligible for participation, individuals were required to meet the following inclusion criteria: (a) identify as a person of color; (b) be at least 21 years of age; (c) hold at least a master's degree in clinical mental health; (d) be a fully licensed independent counselors; (e) have experience working on a multidisciplinary team treating the same client; and (f) provide direct counseling services to BIPOC clients diagnosed with EDs.

### **Exclusion Criteria**

Exclusion criteria for this study included individuals who do not identify as BIPOC counselors and those who are not proficient in English. Additionally, individuals who declined to sign the informed consent form were deemed ineligible to participate. Participants without experience working on multidisciplinary teams or providing counseling services to BIPOC clients diagnosed with eating disorders were also excluded from the study.

## **Procedures for Recruitment**

I asked potential participants to complete a demographic questionnaire that collected information regarding their race, gender, age, and number of years working in the field, providing additional context about each participant. I provided individuals who met the eligibility requirements and agreed to participate were provided with a detailed informed consent form outlining the study's purpose, the intended use of the collected data, and its potential significance for future publication. To indicate their consent, I asked participants to respond electronically with the phrase, "I consent".

## **Instrumentation**

I conducted semistructured interviews (see Shelton & Bridges, 2019; Willig & Rogers, 2017), lasting 60 minutes using Zoom, a synchronous online video platform. Only audio was recorded during these sessions; however, the camera remained on to allow me to observe participants' nonverbal body language throughout the interviews. Interviews were conducted from my home or workplace office. As the principal researcher, I functioned as the primary instrument for data collection during the interview process (see Peoples, 2021; Shelton & Bridges, 2019).

I used an interview guide (see Appendix A) consisting of semistructured questions aligned with the focus of the study. This format helped maintain consistency across interviews while allowing flexibility to explore participants' responses through follow-up questions (see Patton, 2015; Shelton & Bridges, 2019). I provided a brief explanation of the research process and reviewed the informed consent form. Participants provided verbal consent before audio recording began (see Ravitch & Carl, 2021). As

part of the consent process, participants also completed a demographic questionnaire that collected information about their race, age, gender, and years of experience working in the ED field.

Following the interviews, I debriefed participants with a brief overview of the study's research purpose and the significance of their contribution (Shelton & Bridges, 2019). They were reminded that all audio recordings, transcripts, and notes are to be kept confidential and stored securely, accessible only to the researcher. Participants also had the opportunity to receive the summary of the data supporting emergent themes, a process known as member checking, which can be especially beneficial for marginalized populations (Jefferson et al., 2024). I provided transcript reviews prior to the submission and publication of the research. Additionally, they were given the opportunity to ask any further questions or provide comments regarding the interview process (Rubin & Rubin, 2011).

### **Data Analysis Plan**

I used a semistructured interview protocol to guide the interviews, which allowed me to ask probing questions based on the participants' responses to gather more in-depth information (Rubin & Rubin, 2011). Audio-recorded interviews were transcribed and analyzed using the ATLAS.ti software. This program assisted in organizing the data, facilitating the coding process, and identifying emerging themes across the interviews (ATLAS.ti, n.d.). During the interview data collection process, I followed Giorgi's (2009) five-step descriptive phenomenological psychological method of data analysis to

assist BIPOC counselors in articulating and describing their experiences of working in the ED field.

***Step 1: Thoroughly Read the Full Transcript***

In this step, the researcher reads each transcript in its entirety. This initial reading is essential for developing a comprehensive understanding of the participant's experience prior to engaging in formal data analysis (Willig & Rogers, 2017). At this stage, the researcher refrains from interpretation or critical questioning and instead focuses on gaining a basic sense of the participant's full description (Shelton & Bridges, 2019; Willig & Rogers, 2017).

***Step 2: Adopt the Attitude of Phenomenological Reduction***

In Step 2, the researcher adopts the attitude of phenomenological psychological reduction (Willig & Rogers, 2017). This step allows the researcher to engage with participants' description of their experiences without imposing preconceived assumptions or prior knowledge (Shelton & Bridges, 2019). Maintaining this stance encourages openness and facilitates a deeper understanding of the phenomenon as described by participants.

***Step 3: Section the Transcripts Into Meaning Units***

This step involves dividing the transcript into distinct meaning units that capture the essence of participants' expressions or everyday language that captures the psychological meaning of the phenomenon (Giorgi, 2012; Shelton & Bridges, 2019). Each time the researcher identifies a shift in meaning during the reading process, the section is marked accordingly and the reading continues (Willig & Rogers, 2017). At this

stage, differences in meaning are noted but are not yet subjected to interpretation or analysis (Giorgi & Rogers, 2017).

***Step 4: Convert Each Meaning Unit Into Phenomenologically Psychologically Informed Descriptions***

In this step, the researcher evaluates the meaning units and rephrases them into phenomenologically psychologically informed descriptions (Shelton & Bridges, 2019). The transformed meaning units are then organized to form integrated descriptions that eliminate redundancies while highlighting participants' lived experiences, which can later be categorized into themes (Giorgi, 2012; Shelton & Bridges, 2019). This process requires the researcher to carefully translate participants' everyday language into language that reflects the psychological significance of their experiences while remaining faithful to the original meaning (Shelton & Bridges, 2019).

***Step 5: Structure the Results***

The last step involves identifying the general structure of the experience by developing a rich, descriptive summary grounded in participants narratives (Willig & Rogers, 2017). This summary integrates the transformed meaning units and themes to present a cohesive understanding of the phenomenon as experienced by participants (Shelton & Bridges, 2019). The resulting structure provides insight into the shared essence of participants' experiences while preserving the contextual details that shape their lived realities with the ED field.

## **Issues of Trustworthiness**

In qualitative research, trustworthiness refers to the overall quality, rigor, and credibility of the study (Burkholder et al., 2020). It is evaluated through established criteria, including credibility, transferability, dependability, and confirmability (Ravitch & Carl, 2021). I employed these core components to ensure the rigor and trustworthiness of this study.

### **Credibility**

Credibility in qualitative research refers to the extent to which the study's findings are believable and accurately reflect the data presented (Burkholder et al., 2020).

Credibility can be established through various strategies, including prolonged engagement, member checking, triangulation, persistent observation, negative case analysis, peer debriefing, and reflexivity (Burkholder et al., 2020). For this study, I employed peer debriefing and reflexivity to enhance credibility. Peer debriefing involved engaging in ongoing dialogue with a qualified peer who is not involved in the study at multiple points throughout the research process (see Burkholder et al., 2020).

Documentation of these reflections included journals, memos, and field notes. I set aside time to journal after each interview to critically assess the emergence of any potential biases, reflect on how they were addressed, and identify strategies for managing them in future interviews.

### **Transferability**

Transferability refers to the extent to which the findings of a study may be applicable or relevant to other contexts or populations (Burkholder et al., 2020).

Researchers support transferability by providing comprehensive and detailed descriptions of the research context and the foundational assumptions of the study, allowing readers to determine the potential applicability of the findings to their own settings. (Burkholder et al., 2020). In this study, I used thick descriptions, which involved presenting rich, detailed accounts of the findings (see Burkholder et a., 2020). This included incorporating direct quotations from participant interviews as well as insights drawn from my reflexive journal.

### **Dependability**

Dependability refers to the consistency and reliability of the research process, including data collection, analysis, reporting, and the documentation of any methodological changes (Burkholder et al., 2020). Researchers may employ strategies such as inquiry audits, audit trails, and triangulation to establish dependability (Burkholder et al., 2020). In this study, I maintained an audit trail by systematically documenting the procedures used for data collection, the development of coding categories, and the rationale behind key decisions made throughout the research process (see Burkholder et al., 2020).

### **Confirmability**

Confirmability refers to the extent to which the findings of a study are shaped by the participants' responses rather than researcher bias, ensuring that the results are grounded in the collected data (Burkholder et al., 2020; Ravitch & Carl, 2021). Establishing confirmability requires transparency in the research process so that other researchers could reach similar conclusions when examining the same data (Ravitch &

Carl, 2021). To support confirmability, I maintained comprehensive audit trails throughout the research process and carefully documented each step of the study. This documentation enhanced transparency and demonstrated that the findings were derived from the data rather than personal assumptions.

### **Ethical Procedures**

This study adhered to the ethical guidelines established by the American Counseling Association (ACA) to protect the welfare and rights of participants (ACA, 2014). Prior to recruitment and data collection, the study was reviewed and approved by Walden University's Institutional Review Board (IRB). Once approved by the IRB, I was assigned an approval number 08-29-25-1138781. All research procedures, including participant recruitment, informed consent, confidentiality, and data collection and storage, were conducted in accordance with Walden University's IRB ethical standards for the protection of participants.

Recruitment for this study involved purposive and snowball sampling methods to identify fully licensed BIPOC counselors who met the inclusion criteria. Snowball sampling relied on referrals from participants; however, all referred individuals independently reviewed the study information and provided informed consent prior to participation. All recruitment materials clearly outlined the purpose of the study, emphasized the voluntary nature of participation, and included my contact information for additional questions.

Formal approval to recruit participants was obtained from the IAEDP, AED, and relevant social media and listservs platforms. Participants were contacted only through

email or Zoom. Given the study's focus on the lived experiences of BIPOC counselors, it was anticipated that discussions might prompt reflection on experiences with microaggressions, racism, and professional isolation. Participants were informed that they could decline to answer any questions, pause or stop the interview, or withdraw from the study at any time if they experience discomfort. However, participants who felt comfortable were encouraged to share their full experiences to a deeper understanding of the phenomenon under investigation.

Individuals who met the inclusion criteria were provided with an informed consent form outlining the study's purpose, research procedures, potential risks and benefits, the voluntary nature of participation, and their right to withdraw from the study at any time without penalty. Participants indicated their consent by typing the phrase, "I consent." Prior to the start of each interview, I verbally reviewed the consent process, addressed any questions, and obtained verbal permission to proceed with the interview and to audio recording. I also informed participants that pseudonyms would be assigned to protect their identities.

I collected data through semistructured interviews conducted via Zoom, a secure and HIPAA-compliant video conferencing platform. However, only audio recordings were made to further protect the participant's confidentiality. Participants were reminded to refrain from sharing personally identifying information during the interview. All interviews were conducted from a private and secure location to ensure confidentiality and minimize interruptions. Because of the potentially sensitive nature of participants'

professional experiences, care was taken to avoid leading questions. Participants also retained the right to decline to answer any questions that caused discomfort.

All collected data was handled with confidentiality. I transcribed the audio recordings, and any identifying information was removed during the transcription process. Pseudonyms were assigned to all transcripts and used in any subsequent publications or presentations. Confidential data were stored on a password-protected computer and an encrypted external hard drive, both accessible only to the researcher. Zoom recordings were downloaded immediately following each interview and permanently deleted from the cloud. Any handwritten notes and printed documents were securely stored in a locked file cabinet located in my private office. All research data will be retained for five years following the completion of the study and will then be permanently deleted or destroyed in accordance with the guidelines of Walden University's IRB and the ACA.

### **Summary**

This chapter addressed the research questions and explored the lived experiences of BIPOC counselors who collaborated with multidisciplinary teams to provide culturally responsive care to BIPOC clients diagnosed with EDs. This study was guided by a transcendental phenomenological approach, which sought to authentically capture participants' voices while minimizing researcher bias through practices such as bracketing and maintaining a reflexive journal. I recruited participants through purposive and snowball sampling methods and collected data using semistructured interviews. Data analysis followed Giorgi's five-step descriptive phenomenological method to identify

core themes within in participants' experiences. Trustworthiness was established through strategies such as peer debriefing, reflexive journaling, member checking, and the use of thick description to support credibility, transferability, dependability, and confirmability. Ethical procedures were implemented to prioritize participant safety, confidentiality, and informed consent in alignment with ACA ethical standards and Walden University's IRB requirements. Ultimately, in this study, I aimed to contribute to the limited literature on BIPOC counselors in the ED field and to support the development of more inclusive, culturally competent, and responsive care practices.

## Chapter 4: Results

In this chapter, I present the findings of this descriptive transcendental phenomenological study exploring the lived experiences of BIPOC counselors who provide culturally responsive care to BIPOC clients diagnosed with EDs within multidisciplinary teams. The purpose of this study was to address a gap in ED literature by exploring how BIPOC counselors described their level of preparedness to provide culturally responsive care while working within predominantly White clinical spaces. This study was guided by the central research question: What are the lived experiences of BIPOC counselors who collaborate with multidisciplinary teams providing culturally responsive care to BIPOC clients diagnosed with eating disorders? A subquestion was further explored: How do BIPOC counselors describe their level of preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs as part of multidisciplinary teams? The findings presented in this chapter reflect shared meaning structures that emerged across participants' narratives and highlight how these experiences were shaped by education, professional environment, and system dynamics.

In this chapter, I also provide a detailed description of the data collection process, including the research setting, participant demographics, and data sources used in the study. I present the results of the data analysis conducted using Giorgi's (2009) descriptive phenomenological method, outlining the essential themes that emerged from the interview data. To demonstrate methodological rigor and transparency, I also address trustworthiness by describing the strategies used to establish credibility, dependability, transferability, and confirmability throughout the research process.

### **Virtual Setting**

The participants in this study were all located along the East Coast of the United States, ranging from the Northeast to the Southeast. Due to this geographic dispersion, I conducted all interviews using the online videoconferencing platform Zoom. Conducting interviews virtually allowed participants to engage in the research process from locations they felt comfortable with and were accessible to them, which supported participation and scheduling flexibility.

Each in-depth, semistructured interview ranged from 48 to 60 minutes in length. Interviews were conducted synchronously and individually. I conducted each interview in a private setting within my home or professional office space to ensure confidentiality and minimize distractions. Participants were also encouraged to select private, quiet environments to support confidentiality and focused engagement during the interview.

Although the use of Zoom provided several benefits, including convenience, reduced travel burden, and increased accessibility, it also presented minor challenges. On occasion, a participant experienced brief connectivity issues, audio disruptions, or environmental interruptions such as background noise. When these issues occurred, I paused the interview as needed to ensure the participant could be heard clearly and that their responses were accurately captured. No interviews were terminated due to technological difficulties, and all participants were able to complete their interviews in full.

To support transparency and consistency, I provided each participant with a scheduling link that allowed them to select an interview date and time that aligned with

their availability. After a date and time were selected, I sent a confirmation email containing the Zoom link and interview details. Prior to beginning the audio recording, I reviewed the informed consent with each participant, reminded them that participation was voluntary, and emphasized that they could stop the interview at any time or decline to answer any questions. I also reminded participants that the interview would be audio recorded and obtained their verbal permission before proceeding. Once the interview began, I reviewed the inclusion criteria to confirm that each participant met the study's eligibility requirements.

### **Demographics**

A total of six adult BIPOC counselors with experience providing care to BIPOC clients diagnosed with EDs while collaborating within multidisciplinary treatment teams participated in this study. All participants met the inclusion criteria outlined in Chapter 3. Participants represented a range of racial and ethnic identities, age groups, and professional experiences relevant to the phenomenon under investigation.

To protect participant confidentiality, I assigned each participant a pseudonym immediately following recruitment. No personally identifying information was included in interview transcripts, field notes, memos, or the presentation of study results. Pseudonyms were used consistently throughout data analysis, findings, and reporting processes to maintain confidentiality. I stored demographic data separately from interview transcripts in a password-protected file accessible only to the researcher.

Demographic characteristics were collected at the beginning of each interview. These data were used to contextualize participants' experiences rather than to compare

groups or quantify findings, which is consistent with phenomenological research methodology. Table 1 presents participants' demographic characteristics relevant to this study.

**Table 1**

*Participants' Demographic Data*

Participant pseudonym	Age range	Race/ethnicity	Gender
Joya	25–34	Black/African American	Female
Ebony	25–34	Black/African American	Female
Tonya	25–34	Asian	Female
Christina	25–34	Hispanic	Female
Cheryl	35–44	Black/African American	Female
Zuri	35–44	Black/African American	Female

**Data Collection**

I began data collection after receiving approval from the IRB. Recruitment procedures followed the plan outline in Chapter 3. I recruited participants by sending an email invitation (see Appendix B) to professional eating disorder organizations and by posting study invitations on social media platforms and professional Listservs. I also used snowball sampling, allowing participants to share the study information with colleagues who met the inclusion criteria.

All individuals who expressed interest in the study were screened using the established inclusion criteria. Eligible participants were emailed the informed consent document along with written instructions outlining the next steps in the research process. This recruitment and screening process was documented in the audit trail to support transparency and ensure methodological rigor.

**Sample Size**

A total of eight prospective participants met the study's inclusion criteria. Of these eight individuals, two withdrew prior to the start of the interviews due to scheduling conflicts and personal time constraints. No participants withdrew after the interview process began. The remaining six participants voluntarily provided informed consent by replying to the consent email with the statement, "I consent", as approved by the IRB.

After receiving informed consent, I offered participants a range of available interview dates and times. Participants selected interview times that best fit their schedules. I then sent a confirmation email that included the interview date, time, and Zoom link. All six participants completed their interviews as scheduled.

**Semistructured Interview**

I collected primary data through semistructured interviews with all six participants. Each participant completed one individual interview. No follow-up interviews were required, as participants provided rich and sufficient data to address the research questions. I used a semistructured interview protocol to guide each interview, allowing for consistency across interviews while also providing flexibility for participants to elaborate on experiences that were meaningful to them. Prior to beginning the audio recording, I reviewed the purpose of the study and revisited the informed consent, reminding participants that participation was voluntary, that they could end the interview at any time, and that they could skip any questions they found uncomfortable or difficult to answer. Participants were given the opportunity to ask questions before the recording began. I then obtained verbal consent to proceed with audio recording.

Interview questions prompted participants to describe their lived experiences working in the ED field and collaborating within multidisciplinary treatment teams while serving BIPOC clients. Participants discussed their educational backgrounds and training, experiences working in predominantly White clinical settings, advocacy efforts on behalf of BIPOC clients, and recommendations for improving education, training, and systemic practices within the ED field.

Following the completion of each interview, I conducted a debriefing with participants. During this time, I reiterated the purpose of the study, explained the data analysis process, and described the member-checking procedure. Participants were informed that they would be asked to review a brief summary of their interview findings and that this process would take approximately 10-15 minutes. I provided my contact information and reminded participants of available support resources should they experience any distress related to their participation.

### **Memos**

In addition to interview transcripts, I recorded memos during and immediately following each interview. These memos included observational data such as participants' tone, affect, pauses, and moments of notable emphasis, as well as my immediate reflections on the interview process (see Ravitch & Carl, 2021). I also documented contextual factors, including technological disruptions and environmental interruptions, when they occurred.

I used memos to support reflexivity and transparency rather than to generate independent data (see Ravitch & Carl, 2021). They contributed to the audit trail and were

used during data analysis to help contextualize meaning units and support bracketing of assumptions. The memos were stored securely and reviewed alongside the interview transcripts during analysis to enhance credibility and dependability (see Burkholder et al., 2020; Ravitch & Carl, 2021).

### **Data Analysis**

For this phenomenological qualitative study, I followed Giorgi's (2009) descriptive phenomenological method, which is designed to identify and describe the structure of the lived experiences. This approach was used to examine the experiences of BIPOC counselors working in the ED field while collaborating within multidisciplinary teams treating BIPOC clients with EDs. The descriptive phenomenology emphasizes describing participants' psychological experiences rather than interpreting them (Giorgi, 2009; Willig & Rogers, 2017). This approach also requires the researcher to bracket personal assumptions in order to remain grounded in the participants' lived experiences (Willig & Rogers, 2017). The data analysis process involved five systematic steps: (a) reading each full transcript in its entirety, (b) adopting a phenomenological reduction stance, (c) dividing the transcripts into meaning units, (d) transforming each meaning unit into themes, and (e) synthesizing and structuring the results.

#### **Step 1: Reading Each Full Transcript in Its Entirety**

I read each interview transcript in its entirety multiple times to gain a comprehensive understanding of the participants' experiences as BIPOC counselors working in ED treatment settings. During this stage of the process, I did not code or categorize the information. The purpose was to immerse myself in the data and become

familiar with and understand the overall tone, context, and meaning of the participants' narratives (Shelton & Bridges, 2019; Willig & Rogers, 2017). This process allowed me to bracket prior assumptions and attend closely to how the participants described their lived experiences in their own words.

### **Step 2: Adopting a Phenomenological Reduction Stance**

I adopted an attitude of psychological reduction given my professional proximity to BIPOC counselors working the ED field. I intentionally suspended my assumptions and used reflexive journaling to support the process of psychological reduction. This practice allowed me to attend to the participants' descriptions of their experiences rather than relying on my own interpretations or prior knowledge. Maintaining this practice is central to Giorgi's method and supports descriptive validity by prioritizing the participants' narratives over preexisting assumptions (Willig & Rogers, 2017).

### **Step 3: Dividing the Transcripts Into Meaning Units**

I uploaded the interview transcripts into the ATLAS.ti qualitative data analysis software to support data organization and facilitate the identification of meaning units. After reading each transcript, I conducted a line-by-line review to identify shifts in meaning. Meaning units were determined based on shifts in the significance of the participants' descriptions of their lived experiences (Shelton & Bridges, 2019). For example, a participant's description of entering the ED field unexpectedly differed from later reflections on feeling unprepared due to limited training. Examples of raw meaning units included Joya's statement, "I don't recall the words eating disorder ever coming up in my program," and Ebony's reflection, "I just kind of fell into eating disorders because

I needed hours”. These meaning units reflected distinct moments in participants’ experiences related to entry into the ED field and educational preparation.

After identifying the meaning units, I transformed them from the participants’ everyday language into psychological expressions while maintaining the original meaning (Willig & Rogers, 2017). This transformation involved rephrasing the meaning units to capture their psychological significance in relation to the research questions while avoiding interpretation or the introduction of theoretical explanations (Shelton & Bridges, 2019; Willig & Rogers, 2017). For example, the meaning unit “I had to learn everything as I went” from Tonya, was transformed into the expression that participants developed clinical competence through immersion due to limited formal training. Similarly, Ebony’s statement “It felt like it was on me to explain culture” was transformed to reflect that cultural responsiveness was experienced as an individual responsibility rather than an institutional practice.

#### **Step 4: Transforming Each Meaning Unit Into Themes**

I compared the transformed meaning units across transcripts by printing them and arranging them on a large wall to assist with organization and visualization. Through this process, I clustered related meaning units into essential themes that captured the shared structures of participants’ experiences (Willig & Rogers, 2017). These themes were continuously refined through comparison with the original transcripts to ensure alignment with the participant’s descriptions. Five essential themes emerged from this process: nontraditional entry into the ED field; lack of education and training and the need for structural and educational change; diagnosis prioritized over personhood; marginalization

in predominantly White spaces; advocacy as emotional and professional risk; and cultural responsiveness as individual responsibility. Four subthemes also emerged: nontraditional entry into ED field, learning through immersion, the need for structural change and representation, and reflexivity and unlearning cultural conditioning. Themes were considered essential when they appeared across multiple participants and reflected core aspects of the phenomenon under investigation.

I used exemplar quotations to ground the themes in participants' own voices. For example, the theme of cultural responsiveness as an individual responsibility was reflected in Ebony's statement, "It felt like it was on me". Similarly, marginalization within multidisciplinary teams was illustrated by Joya's reflection, "I didn't feel like I had a voice". These quotations were intentionally selected to convey shared meaning across participants rather than the frequency of similar statements.

### **Step 5: Synthesizing and Structuring the Results**

In the final step, I synthesized all themes into a composite textural description, a composite structural description, and an integrated essence of the phenomenon (see Willig & Rogers, 2017). The composite textural description captured what the participants experienced by integrating their shared accounts of thoughts, feelings, actions, and meanings related to providing culturally responsive care to BIPOC clients diagnosed with EDs (see Willig & Rogers, 2017). I then developed a composite structural description to explain how these experiences occurred by describing the contextual, relational, and systemic conditions shaping participants' experiences across clinical settings. This synthesis revealed the invariant structure of the phenomenon across

participants' narratives. The resulting essence illustrated how BIPOC counselors experienced providing culturally responsive ED care within multidisciplinary teams. Their experiences involved navigating systemic inequities, carrying often invisible cultural labor, and engaging in ongoing advocacy while maintaining a commitment to humanizing and affirming care for their clients. Table 2 presents the development of themes, illustrating the movement from raw meaning units to psychologically sensitive expressions and ultimately to the thematic structure.

**Table 2***Themes Developed Using Giorgi's Descriptive Phenomenological Method*

Essential theme and subtheme	Representative meaning unit (condensed)	Transformed psychological meaning
Theme 1: Lack of education and training and the need for structural and educational change	"It never came up", "We barely talked about it"	Graduate education programs inadequately prepared counselors to recognize or treat EDs, particularly among BIPOC populations.
Subtheme 1a: Nontraditional entry into ED field	"I fell into it", "I needed hours", "I didn't plan this"	Entry into the ED field occurred unintentionally rather than through intentional specialization, reflecting limited visibility of Eds for BIPOC counselors.
Subtheme 1b: Learning through immersion	"I learned as I went", "Trial and error", "I had to teach myself"	Clinical competence developed through experiential learning rather than formal preparation, requiring additional work from BIPOC counselors.
Subtheme 1c: Need for structural and educational change and representation	"We need more training", "We need representation"	Participants identified systemic reform as essential for sustainable culturally responsive ED care.
Theme 2: Diagnosis prioritized over personhood	"They saw the diagnosis", "They didn't see the family"	Multidisciplinary teams prioritized biomedical criteria over contextual, cultural, and relational factors.
Theme 3: Marginalization in predominantly White spaces	"I didn't have a voice", "I had to assimilate"	Participants experienced silencing, self-monitoring, and identity negotiation within White-dominated clinical settings.
Theme 4: Advocacy as emotional and professional risk	"I escalated it", "I pushed anyway"	Advocacy required persistence and emotional labor and often involved fear of professional repercussions.
Theme 5: Cultural responsiveness as individual responsibility	"I had to figure it out", "I carried that responsibility"	Cultural responsiveness was experienced as a personal obligation rather than a shared institutional practice.
Subtheme 5a: Reflexivity and unlearning cultural conditioning	"I had to check myself", "I had to unlearn"	Effective care required ongoing self-reflection regarding culturally inherited beliefs about food, health, and bodies.

### **Discrepant Cases and Variations**

In descriptive phenomenological research, variations and discrepant expressions are examined to refine rather than invalidate the essential structure of the phenomenon (Antin et al., 2014). Accordingly, discrepant cases were treated as meaningful variations that enhanced analytic rigor and helped guard against overgeneralization (Antin et al., 2014). This approach is consistent with phenomenological principles that emphasize structural invariance while honoring individual differences (Giorgi et al., 2017; Shelton & Bridges, 2019).

Although I observed strong thematic consistency across participants, I carefully examined variations in how themes were expressed rather than excluding them. For example, while all participants described limited formal education in EDs, one participant reported receiving brief exposure during training. I did not treat this account as contradictory; instead, I incorporated it as a meaningful variation that reinforced the broader theme of inadequate preparation rather than negating it.

Similarly, not all participants described experiences of marginalization in the same way. Some participants reported overt silencing within multidisciplinary teams, whereas others described more subtle forms of assimilation or self-monitoring. I analyzed these differences to ensure that the themes reflected shared meaning structures while honoring individual variation, consistent with phenomenological methodology (Antin et al., 2014). Discrepant expressions were used to refine thematic boundaries and prevent overgeneralization. No participant narratives contradicted the essential structure of the

phenomenon, and no new themes emerged during later stages of analysis, supporting thematic saturation.

### **Evidence of Trustworthiness**

Establishing trustworthiness is priority in this qualitative descriptive phenomenological study. In alignment with the strategies discussed in Chapter 3, I implemented procedures to enhance credibility, transferability, dependability, and confirmability throughout the data collection process and analysis. Trustworthiness in qualitative research reflects the rigor, transparency, and ethical responsibility of the researcher in representing participants' lived experiences accurately and faithfully (Burkholder et al., 2020; Ravitch & Carl, 2021).

### **Credibility**

Credibility refers to the extent to which findings accurately represent participants' experiences and meanings as intended (Burkholder et al., 2020). To enhance credibility, I engaged in prolonged engagement with the data, reflexive practices, and member checking, as described in Chapter 3. Each interview transcript was reviewed multiple times to ensure familiarity with participants' narratives and to remain grounded in their descriptions throughout analysis.

I conducted member checking by providing participants with a summary of the essential themes and select exemplar quotations derived from their interviews. Participants were invited to review these summaries and indicate whether the findings accurately reflected their experiences. All participants confirmed that the themes resonated with their lived experiences, and no participants requested revisions. This

process strengthened credibility by ensuring that the findings aligned with participants' perspectives rather than researcher assumptions (Ravitch & Carl, 2021).

Additionally, credibility was supported through the use of exemplar quotations in Chapter 4 to attach themes in participants' own words. Quotations were selected intentionally to illustrate shared meaning structures rather than frequency, consistent with phenomenological reporting practices. Throughout analysis, I engaged in reflexive journaling to document my assumptions, reactions, and analytic decisions, which allowed me to bracket presuppositions and remain attentive to participants' voices (Burkholder et al., 2020).

### **Transferability**

Transferability refers to the extent to which findings may be applicable to other contexts or settings, as determined by the reader rather than the researcher (Burkholder et al., 2020). To support transferability, I provided thick, rich description of the research context, participants, and analytic process. Detailed descriptions of participants' professional roles, treatment settings, and experiences working within multidisciplinary teams were included to allow readers to assess the relevance of the findings to similar contexts.

Rather than seeking generalizability, which is inconsistent with phenomenological inquiry, I focused on presenting sufficient contextual detail to support analytic transfer (Ravitch & Carl, 2021). The inclusion of a cross-participant themes matrix further strengthened transferability by demonstrating how themes were represented across participants, highlighting both shared structures and individual differences. These

strategies aligned with the transferability plan outlined in Chapter 3 and allowed readers to make informed judgments about the applicability of the findings.

### **Dependability**

Dependability addresses the consistency and stability of the research process over time (Burkholder et al., 2020). To establish dependability, I maintained a comprehensive audit trail documenting each phase of the research process, including recruitment procedures, interview protocols, transcription verification, analytic decisions, and theme development. This audit trail provided a transparent record of how data were collected and analyzed, allowing for replication of the analytic process.

I applied Giorgi's (2009) five-step descriptive phenomenological method consistently across all transcripts, as described in Chapter 3. Meaning units were identified, transformed, and clustered using the same analytic criteria for each participant. I also engaged in iterative review of themes to ensure their stability and coherence across the dataset. The creation of analytic matrices, including the cross-participant master themes matrix, further supported dependability by documenting how themes were derived and refined across cases (Ravitch & Carl, 2021).

### **Confirmability**

Confirmability refers to the degree to which findings are grounded in the data rather than shaped by researcher bias or preference (Burkholder et al., 2020). I supported confirmability through reflexive journaling, bracketing, and documentation of analytic decisions. Reflexive memos captured my positionality, emotional responses, and

evolving understanding of the data, allowing me to examine how my perspectives may have influenced interpretation.

To further support confirmability, all themes were explicitly grounded in participants' verbatim statements, with exemplar quotations used to demonstrate the link between data and findings. The audit trail served as an additional confirmability strategy by providing evidence of how interpretations were derived. These strategies ensured that the findings reflected participants' lived experiences rather than researcher assumptions (Ravitch & Carl, 2021).

### **Results of the Study**

The purpose of this descriptive phenomenological study was to explore the lived experiences of BIPOC counselors providing culturally responsive care to BIPOC clients diagnosed with EDs while collaborating within multidisciplinary treatment teams. This section presents the results of the data analysis conducted using Giorgi's (2009) descriptive phenomenological method. Across the six participant interviews, five essential themes and three subthemes emerged, representing shared meaning structures shaping participants' experiences working within ED treatment systems. Exemplar quotations are included to ground findings in participants' lived experiences. Discrepant data is also discussed to demonstrate analytic rigor.

Analysis yielded five essential themes: (a) the lack of education and training and the need for structural and educational changes, (b) diagnosis prioritized over personhood, (c) marginalization in predominantly White spaces, (d) advocacy as emotional and professional risk, and (e) cultural responsiveness as individual

responsibility. Subthemes included nontraditional entry into the ED field, learning through immersion, and a call for structural change and representation under Theme 1, and reflexivity and unlearning cultural conditioning under Theme 5. The first theme, endorsed by all six participants, reflected participants' collective experience of entering the ED field without sufficient formal preparation and developing competence largely through experiential exposure rather than structured training.

**Table 3***Cross-Participant Matrix of Essential Themes*

Essential theme	Ebony	Joya	Christina	Tonya	Cheryl	Zuri
Theme 1: Lack of education and training and the need for structural and educational changes	X	X	X	X	X	X
Subtheme 1a: Nontraditional entry into ED field	X	X	X	X	X	X
Subtheme 1b: Learning through immersion	X	X	X	X	X	X
Subtheme 1c: Call for structural change and representation	X	X	X	X	X	X
Theme 2: Diagnosis prioritized over personhood		X	X	X		X
Theme 3: Marginalization in predominantly White spaces	X	X	X		X	X
Theme 4: Advocacy as emotional and professional risk	X	X	X	X		X
Theme 5: Cultural responsiveness as individual responsibility	X	X	X	X	X	X
Subtheme 5a: Reflexivity and unlearning cultural conditioning		X	X	X	X	X

*Note.* X indicates that the participant explicitly referenced meaning units contributing to the theme during their interview. Blank cells indicate the theme was not explicitly articulated by that participant, though it may have been implicitly present.

### **Emergent Themes**

Analysis of the interview data revealed several essential themes describing participants' lived experiences within ED treatment settings and multidisciplinary teams. These themes captured how participants entered the field, navigated team dynamics, experienced marginalization, and engaged in advocacy on behalf of their BIPOC clients. The first essential theme, Lack of Education and Training and the Need for Structural and Educational Change, highlighted the absence of formal preparation of ED work within participants' graduate training. Participants rarely described a direct or structured

pathway into ED treatment. Instead, many reported entering the field through unexpected opportunities, clinical placement experiences, or general mental health roles that later evolved into ED-focused positions. Participants emphasized that this nontraditional entry shaped their early professional identities and often required them to learn ED-specific knowledge and culturally responsive strategies through on-the-job learning.

### **Theme 1: Lack of Education and Training and the Need for Structural and Educational Change**

All participants reported minimal exposure to EDs during graduate training, consistent with the literature documenting persistent gaps in counselor education related to EDs and culturally responsive ED treatment (Goel et al., 2022; Irvine & Labarta, 2024; Labarta et al., 2023). Participants described entering ED work without foundational knowledge of ED assessment, medical risk, treatment structures, or culturally responsive care. Several participants emphasized that their learning occurred only after they had entered the field.

This theme reflected a broader pattern in which EDs were framed as a niche specialty rather than an essential clinical competency. Such positioning may contribute to delayed recognition of EDs in BIPOC communities and limit early preparedness among counselors of color (Labarta et al., 2023). Participants' accounts also suggested that this educational omission contributed to inequities in practice by placing additional responsibility on BIPOC counselors to pursue independent learning while simultaneously navigating predominately White clinical environments (Biang et al., 2024). As participants reflected on their preparation, they consistently positioned ED training gaps

not as individual shortcomings but as systemic omissions within counselor education and clinical training pathways (Goel et al., 2022; Irvine & Labarta, 2024). Joya highlighted how the absence of ED content in training was subtle but structural, describing how graduate curricula often overlook EDs even in coursework intended to address complex mental health presentations:

In school, I don't recall eating disorders ever really being discussed. Now, as a professor in a master's counseling program, I intentionally bring up eating disorders as an underserved population. If you're not in that world, you don't know enough about it. In classes like multicultural counseling or crisis counseling, there's a heavy focus on substance use and common crises, but not enough attention on the medical and mental health components of eating disorders.

Joya's reflection underscored that limited ED education was not only an issue for practicing clinicians but also a curricular gap that continues to reproduce itself across training programs. Her perspective also demonstrated how participants' professional growth required them to later reconstruct missing knowledge to ethically support clients presenting with EDs, particularly when cultural and medical complexities intersected. As a result, BIPOC counselors frequently developed competence through lived experience, mentorship, and direct clinical exposure rather than through structured training pathways. Ebony added,

I went into the field with no knowledge of eating disorders, no background at all related eating disorders. And then I got into it, and I loved it. I really fell in love

with the work. Thinking back, even during schooling, I don't really remember learning about eating disorders. If anything, they were grouped under mental health, but I never really talked about them or heard about them directly. Even growing up, eating disorders weren't a thing that was talked about. I honestly don't remember really learning or knowing about eating disorders until I got into the field. It was new on every level.

Ebony's account further reinforced that inadequate ED education left clinicians underprepared not only for treatment responsibilities but also for understanding the cultural dynamics shaping how BIPOC clients and families experience ED care. Her narrative suggested that training programs often fail to address how ED interventions may unintentionally center White cultural norms related to food, family systems, body image, and help-seeking behaviors. Consequently, BIPOC counselors frequently described learning through practice while simultaneously serving as cultural translators within treatment teams. This expectation aligns with patterns of professional marginalization documented in ED and healthcare literature (Biang et al., 2024; Irvine & Labarta, 2024). Zuri shared,

I started in eating disorders on a whim. I didn't realize the job I was applying for was even a real thing because the company was new, and I had not heard about them before. Eating disorders were never really taught heavily in school, so once I went down that path to explore what the opportunity was, it intrigued me. That's how I got started. I had no strong desire to be into it, but I had curiosity once I opened the door.

Zuri's statement emphasized how the absence of structured ED education translated into real-world inequities, requiring BIPOC clinicians to bridge gaps in culturally responsive treatment through self-education and professional advocacy. Across participants' narratives, the lack of training was described as a foundational context shaping their early professional identities. Participants consistently described needing to develop ED treatment competence while simultaneously working within high-acuity clinical environments. The lack of structured ED education influenced not only participants' preparedness but also the manner in which they entered the field. All six participants reported that their entry occurred through circumstance, workforce needs, or clinical hour requirements, which formed the basis of the subtheme nontraditional entry into the ED field.

***Subtheme 1a: Nontraditional Entry Into the ED Field***

All six participants consistently described entering the ED field unintentionally, often through employment opportunities rather than purposeful career planning. EDs were not initially perceived as relevant to BIPOC communities during participants' training or early career development, a pattern consistent with documented underrepresentation in ED education and outreach (Goel et al., 2022; Woodruff et al., 2020). Illustrating the nontraditional and unplanned nature of entry into the ED field, Ebony explained that her pathway into ED work emerged primarily from workforce needs and clinical hour requirements.

My program focused on developmental and intellectual disabilities, rehabilitation counseling ... so I thought maybe I'd go into vocational rehab or something like

that. But really, I was just looking for a job. I was looking for something to do, and I kind of fell into eating disorders because I needed hours and the job was available.

Ebony's account reflected how entry into the ED field was shaped less by long-term career planning and more by access, circumstances, and the immediate need to obtain required clinical hours. Her narrative also highlighted how her graduate training did not explicitly position ED work as a relevant specialization, particularly in relation to marginalized populations. This pattern of entering the field through practicality rather than intentional specialization was echoed in Joya's description of her pathway into ED treatment:

My entry into the eating disorder field was very nontraditional. I was coming out of private practice, and the caseload wasn't steady. As an associate licensed clinician at that time, I needed a certain number of client contact hours, so I was looking for treatment center experience. I wanted something more structured and a higher level of care. I found a position at an eating disorder treatment center and thought it would be a good opportunity to widen my scope beyond outpatient work.

Similar to Ebony, Joya emphasized that her entry into the ED field was not driven by an initial intention to specialize in ED treatment but rather by professional needs and evolving career circumstances. Her narrative underscored how the structure of higher levels of care created an opportunity to expand her clinical scope beyond outpatient private practice. Tonya likewise described a pathway that reflected movement in and out

the ED field, shaped by opportunity and career transitions rather than early professional identification with ED work. Tonya reflected,

My first job after graduation ended up being as a therapeutic assistant at a residential eating disorder program. I don't think I really understood what residential treatment meant before that. It wasn't until I worked at the facility that I saw how sick patients really were. I wasn't providing therapy at that point, but I was reinforcing skills and supporting patients, and that experience increased my interest even more. I didn't necessarily set out to become an eating disorder therapist, but I kept coming back to the work. I eventually became licensed and left to do non-eating disorder work like trauma, anxiety, and depression with school-aged kids. Then an opening came up at the eating disorder facility, and I went back.

Tonya's narrative further illustrates how entry into the ED field often occurred through circumstance and professional opportunity rather than intentional specialization, highlighting the nontraditional pathways common in this area of practice. Her reflections also demonstrate that early exposure to the acuity of ED treatment settings served as a pivotal professional turning point, strengthening her commitment to the work even in the absence of structured preparation. Tonya's experience suggests that BIPOC counselors may be drawn into ED work through real-world clinical exposure before fully understanding the scope or demands of the setting. Because participants described entering the ED treatment without adequate educational grounding, they consistently emphasized that competence was developed after entry through direct practice and

experiential learning. This gap between formal training and clinical demands contributed directly to the next subtheme: learning through immersion.

***Subtheme 1b: Learning Through Immersion***

All six participants described developing competence in ED treatment primarily through immersion, relying on supervision, continuing education, self-directed learning, and trial-and-error rather than structured graduate preparation. Although participants entered the field with general counseling skills, they emphasized that culturally responsive ED treatment required specialized knowledge that was not explicitly taught in their training programs. As a result, participants reported learning through direct work with clients, observing multidisciplinary team approaches, and adapting interventions in real time as cultural and contextual needs emerged. This learning process was often described as demanding because participants were simultaneously expected to perform at a high clinical level while still acquiring ED-specific and culturally responsive competencies. Overall, this subtheme reflected that immersion served as the primary pathway for preparedness, with professional confidence developing gradually through sustained exposure to the realities of ED treatment settings.

This theme was especially evident in participants' descriptions of the disconnect between cultural competence as an academic concept and culturally responsive ED treatment as an applied clinical skill. Tonya emphasized that preparation for this work emerged through direct client engagement rather than formal instruction:

In terms of preparation, school emphasized cultural competence in theory, but not in application. On the job, there wasn't much training on how to translate eating

disorder treatment across cultures. That part was lacking. I learned by working with each client directly. The more BIPOC clients I worked with, the more my ability to intervene effectively developed.

Tonya's reflection illustrates how participants experienced preparedness as a developmental process shaped through repeated clinical encounters rather than structured educational milestones. Her statement also highlights that culturally responsive ED work required more than general cultural awareness; it required learning how to apply ED treatment principles in ways that reflected cultural food practices, family norms, and community realities. For participants, competence increased over time as immersion created opportunities to practice, reflect, and refine interventions with BIPOC clients in real-world clinical settings. Cheryl stated,

Once I entered the field, most of my training came through supervision. I had an eating-disorder-specific supervisor, which was incredibly helpful. I also completed continuing education courses, read more on my own, and learned through direct experience. Being immersed in the work was what helped the most.

Cheryl's statement further reinforced that immersion-based learning was strengthened when participants had access to ED-specific supervision that supported skill development in a more intentional and structured way. Her comments also reveal how participants often relied on self-directed professional development, including continuing education and independent learning, to compensate for gaps in graduate training. Even with supervision support, however, participants described immersion as the most

influential source of learning, emphasizing that the complexity of ED work required repeated engagement with clients and treatment systems over time. Christina added,

In school, eating disorders were barely covered. There was a small section in psychopathology, but it was glossed over. It deserved much more attention. On the job, I learned by doing and by observing other therapists. I also had to unlearn a lot of societal norms around food and body image. That learning curve was steep.

Christina's narrative illustrates that immersion involved not only gaining new clinical skills but also unlearning internalized societal messages about food and bodies shaped how clinicians initially understood ED recovery and care. Her description of a "steep" learning curve supports the broader pattern that participants' preparedness developed through observation, practice, and ongoing self-education. These experiences underscore that culturally responsive ED competence was largely acquired through lived professional experience rather than formal training alone.

Collectively, participants described immersion as essential yet demanding, positioning it as the primary mechanism through which preparedness was achieved. Importantly, participants did not frame immersion as sufficient to resolve systemic inequities. Instead, immersion-based learning strengthened participants' shared call for structural reform, leading to the next subtheme: the need for structural change and representation.

***Subtheme 1c: The Need for Structural Change and Representation***

Participants frequently emphasized that structural change must begin at entry into the ED field through early education, culturally responsive mentorship, and explicit institutional acknowledgment of racism and microaggressions within treatment spaces. Zuri articulated this need clearly by describing how representation, training, and access to supportive professional networks could improve retention and belonging for new BIPOC counselors:

What would be helpful for new BIPOC counselors coming into the eating disorder field is more education early on, anti-racism, and DEI-type training. If you speak to issues instead of pretending they don't exist, microaggressions, things that make you feel unseen, it lowers disconnection and brings connection. People feel seen. There should also be representation from the beginning not just experts who don't look like me. There are eating disorder experts who do look like me. If you give access to those networks and people who can provide supervision calls or team calls in the first six months, people would feel more included. It took me after my first year, once I got involved with the certifying body, to find culturally competent conversations they hold once a month. It would be great for people to have those resources from the beginning, pointing people in the right direction instead of them having to find it on their own. That wasn't given to me. I had to seek it out for myself.

Zuri's statement reflected how inclusion in ED treatment settings involves more than hiring BIPOC staff; it also requires ensuring early access to meaningful support,

culturally responsive supervision, and professional networks. Her account illustrated that belonging and retention improve when institutions acknowledge the realities of microaggressions and intentionally create structures that reduce isolation. In this way, representation was framed not only as a workforce need but also as a clinical necessity that strengthens culturally responsive care. Cheryl stated,

What's needed going forward is more education, more focused coursework, more eating disorder specific training, and more attention to niche populations.

Professionally, it would help to see more BIPOC therapists in leadership roles, more BIPOC-led trainings, and more inclusive professional environments overall.

Cheryl further highlighted how representation within leadership and training spaces can shift workplace dynamics and increase the likelihood that BIPOC clinicians' perspectives are heard and valued. Her reflections reinforced that structural change must extend beyond patient care and include leadership visibility, organizational culture, and access to advancement opportunities. These changes were described as essential for sustaining BIPOC clinicians in ED treatment spaces and for improving the quality of care delivered to BIPOC clients. Tonya shared "What's needed in the field? More applied cultural competence in education, case studies, real-world examples, and more representation. Not tokenism, but BIPOC clinicians in decision-making roles."

Tonya's statement reinforced the idea that structural change must be operationalized through concrete institutional practices, including accountability for cultural responsiveness across disciplines rather than assigning this responsibility solely to BIPOC clinicians. Her emphasis highlighted how representation, when paired with

culturally responsive policies and leadership participation, can reduce the burden of invisible labor and strengthen multidisciplinary collaboration in ways that support equitable ED treatment outcomes.

Collectively, participants' narratives underscored the importance of systemic reform across counselor education, professional training, and organizational leadership within the ED field. Participants consistently described the absence of structured ED training as a foundational context shaping their early professional development. As a result, this gap between formal training and clinical demands contributed to the earlier subtheme of learning through immersion, further reinforcing participants' calls for structural and educational change.

### **Theme 2: Diagnosis Prioritized Over Personhood**

Four participants consistently described multidisciplinary treatment teams as prioritizing diagnosis, weight restoration, and compliance standards over cultural, relational, and contextual factors. This diagnosis-centered focus mirrored concerns raised in recent literature regarding the biomedical dominance of ED treatment models (Halbeisen et al., 2022; Labarta et al., 2023). Participants noted that treatment decisions were often driven by standardized protocols rooted in Eurocentric assumptions about recovery, family involvement, and food norms. As a result, BIPOC clients were frequently positioned as “noncompliant” when their cultural needs, family values, or lived realities did not align with the dominant treatment expectations. Christina's account captured how this rigid, diagnosis-driven lens shaped team communication and contributed to culturally dismissive treatment planning:

Working on multidisciplinary teams was often frustrating. At times, it felt like team members saw the diagnosis but not the person. I remember a client from Mexico whose family drove an hour for a pass, and the dietitian planned foods that weren't culturally familiar, like string cheese. That felt dismissive and disconnected from the family's reality. I often had to educate both families and team members. Treatment felt standardized for White patients, and I had to advocate for flexibility.

Christina's reflection illustrated how culturally incongruent treatment expectations unintentionally communicate disrespect, particularly when families were making significant efforts to participate in care. Her example also highlighted how "standard" ED treatment practices, such as meal planning and pass structures, often assumed familiarity with predominantly White American food norms. In these situations, Christina described feeling responsible for bridging the cultural gap between providers and families, frequently taking on the additional labor of educating the team while simultaneously supporting clients. Tonya similarly emphasized how team dynamics and standardized clinical frameworks made it difficult for disciplines to respond flexibly to cultural and environmental context. Tonya explained,

Working on multidisciplinary teams ... most of the teams were majority White. There were some BIPOC team members, including some who shared my racial background, but they were the minority. I noticed that some disciplines struggled to see patients as individuals, especially when environment and culture played a role. That came more naturally to me, probably because of my training and

background. I remember Latinx patients in particular, families who spoke Spanish, had different cultural foods. Dietitians often struggled to translate meal plans to cultural foods. Psych providers might recommend medications to families who were hesitant because of cultural stigma. There was often an emphasis on families “not engaging in treatment the expected way.” Treatment felt standardized for White patients and didn’t translate as well for others.

Tonya’s account underscored how standardized treatment expectations often framed cultural differences as barriers rather than meaningful components of the clients’ lived experiences. Her narrative also emphasized that the burden of adaptation frequently fell on BIPOC clinicians, who were more attuned to the ways culture shaped food practices, family dynamics, and engagement in care. Additionally, Tonya highlighted how providers sometimes interpreted culturally rooted hesitancy toward medication or certain interventions as resistance rather than as contextual factors requiring cultural humility and collaborative problem solving. Extending this pattern beyond meal planning, Joya described how diagnosis-driven thinking also appeared in the use of weight thresholds and discharge criteria, at times overriding clinical progress and relational indicators of readiness. Joya added,

Some clinicians viewed patients primarily through their diagnosis rather than as individuals with emotional, familial, and cultural contexts. This became especially evident during discharge planning. I had situations where a BIPOC patient met treatment goals and had strong family support, but team members wanted to prolong treatment because the patient hadn’t reached a specific weight or number

yet. Medical professionals, in particular, sometimes focused solely on numbers. That tunnel vision created tension and eroded trust with families. When disagreements arose, I often encountered research-based arguments, statistics showing better outcomes with longer stays. That was difficult because much of that research doesn't include BIPOC patients. We were applying data from predominately White samples to BIPOC clients without considering cultural context or alternative supports.

Collectively, these accounts demonstrate how diagnosis-centered care contributed to cultural dismissal and increased advocacy burden for BIPOC counselors. These experiences also occurred within predominantly White clinical environments, shaping participants' sense of professional safety and voice. As a result, participants frequently described marginalization as a central component of working within ED treatment systems, which reflected in Theme 3.

### **Theme 3: Marginalization in Predominantly White Spaces**

Participants described working in predominantly White treatment environments where their perspectives were frequently minimized or questioned. These experiences align with existing research documenting racialized silencing and professional marginalization of BIPOC clinicians in healthcare settings (Jennings-Mathis et al., 2020; Biang et al., 2024). Several participants reported that their clinical recommendations were scrutinized more heavily than those of White colleagues, particularly when advocating for BIPOC clients or raising concerns about culturally different practices. Participants also described the emotional toll of feeling isolated within treatment teams, often

carrying the dual responsibility of providing care while simultaneously navigating racialized workplace dynamics. Collectively, these accounts reflected how marginalization shaped both participants' professional confidence and their ability to advocate fully within multidisciplinary decision-making spaces. Joya described one example in which she felt her advocacy for a Black client was met with resistance that she believed was influenced by racialized team dynamics:

Another instance involved an adult Black patient who had struggled with an eating disorder for nearly ten years. It was her first time in treatment, and I was advocating for more time in PHP. She was close to weight restoration, but emotionally, she needed more stability. I received pushback. I noticed I didn't receive the same resistance when advocating for additional time with White patients. At that point in my career, I didn't feel confident to push harder. I was the only BIPOC clinician on the team and felt voiceless.

Joya's narrative highlighted how marginalization occurred not only through overt acts of discrimination but also through subtle patterns of invalidation during clinical decision-making. Her account suggested that power dynamics within teams, particularly when she was the only BIPOC clinician, could influence whether her voice was perceived as credible or authoritative. Similarly, Ebony described how being one of the only Black clinicians within the treatment shaped her sense of visibility, belonging, and self-monitoring in daily interactions.

One of the biggest things that stood out to me was being one of maybe three Black therapists, really one of very few Black people at the job. It was a

predominantly White space. I grew up around people of color my whole life, and suddenly I was working in a space where not only my colleagues didn't look like me, but the clients didn't either... I became more aware of how I talked, how I presented myself, how I used slang, my facial expressions, how I used my hands. There were things I would say or do around people who shared my culture that I wouldn't do in those spaces. It was more about adapting. It wasn't negative but it was different. It required quick adjustment.

Ebony's description expanded the theme beyond clinical disagreement by emphasizing the broader social and cultural adjustments required to function within predominantly White professional environments. Her experience reflected how marginalization can manifest as a constant need to monitor language, behavior, and presentation in order to align with dominant workplace norms. Cheryl further reinforced this theme by describing how these dynamics extended into leadership structures and professional spaces outside direct patient care, contributing to ongoing feelings of isolation and uncertainty about whether one's voice would be heard or valued.

Being a BIPOC therapist in a predominantly White space can make you wonder if you'll be heard. Leadership often doesn't look like you. You question whether your input carries the same weight. I do work for a company that advocates for inclusion, which helps, but it still doesn't make those conversations easy. Outside of patient care, even professional spaces can feel isolating. At company-wide events, you can visibly see how few people look like you. As Black therapists, we sometimes gather together, take pictures, wear shirts that say, "Black Mental

Health Matters,” and even then, you notice the looks you get. It doesn’t always feel comfortable.

Cheryl’s statement underscores how marginalization may be reinforced through the visible absence of representation within organizational hierarchies, shaping ongoing uncertainty about voice, belonging, and professional legitimacy. Her narrative also illustrates how even affirming identity practices can become racialized in predominantly White environments. Together, these narratives indicate that marginalization shaped both clinical practice and emotional safety within participants’ environments. As a result, speaking up within multidisciplinary teams were often experienced as personally and professionally risky. Consequently, advocacy emerged as a persistent responsibility for participants, reflected in Theme 4.

#### **Theme 4: Advocacy as Emotional and Professional Risk**

Advocacy emerged as a defining aspect of participants’ lived experiences. Five participants described advocating for culturally appropriate food options, flexibility in treatment plans, and greater family inclusion, often at personal and professional cost. These experiences echoed findings by Bray et al. (2025), who noted that clinicians of color frequently carry an additional advocacy burden that contributes to emotional fatigue and professional strain. Participants emphasized that advocacy was not an occasional responsibility but an ongoing requirement that shaped their relationships with colleagues and influenced how safe they felt speaking up within team structures. Across narratives, advocacy was described as necessary for client wellbeing while simultaneously placing participants in vulnerable positions where they risked being viewed as “difficult”,

dismissed, or professionally isolated. Zuri provided a vivid example of how advocacy challenging clinical norms that minimized culturally specific needs. She described escalating concerns to leadership to protect a Black client's mental health and recovery:

A big example of navigating cultural differences with colleagues is hair care. I find myself always advocating for hair care and how important it is to mental health. Patients can't uniquely wash their hair every day like some of their counterparts. They may need braids, and it requires understanding what that entails with Black hair. In treatment, that gets minimized and not taken seriously as part of total patient care. One time, it went all the way up to the Medical Director because I wasn't backing down about a patient getting her hair done. She needed to go to an appointment. She couldn't get her hair braided while she was in treatment, and with a thicker or coarser hair pattern, you can't just wash it. It had to be braided. I wouldn't back down. I was like, it has to get done. Either someone comes on site, or we allow the patient to leave. If her counterparts are able to wash and brush their hair, this is a detriment to her mental health. Her mental health would decline and so would her recovery.

Zuri's account illustrated how advocacy extended beyond treatment planning and into daily cultural realities that were often treated as irrelevant or "nonclinical" by colleagues. Her persistence reflected the ways culturally responsive care required confronting dominant assumptions about what constitutes legitimate health-related needs within ED treatment settings. Similarly, Christina described advocacy as a repeated process of challenging biased assumptions and defending clients' dignity, particularly

when language, culture, or identity influenced how team members interpreted client behavior.

Another instance involved a Mexican American client who spoke Spanglish. Her progress was questioned, and there were assumptions made about her intelligence. That was infuriating. Navigating disagreements required persistence. I advocated respectfully, sometimes one-on-one, sometimes in Teams meetings. Sometimes it was received; sometimes it wasn't.

Christina's account highlighted how advocacy often required confronting biased assumptions embedded within team interactions, particularly when clients' language use or cultural presentation shaped perceptions of competence and treatment progress. Her experience demonstrates that culturally responsive advocacy was not only emotionally taxing but also professionally risky, as it required persistently challenging colleagues in environments where disagreement could be met with defensiveness, dismissal, or subtle forms of retaliation. Collectively, participants' responses in Theme 4 suggests that advocacy functioned as a necessary protective act for BIPOC clients while simultaneously placing BIPOC counselors in professionally vulnerable positions. This advocacy burden was further intensified by the broader finding that culturally responsive care was frequently treated as an individual responsibility rather than shared team commitment, leading into Theme 5.

### **Theme 5: Cultural Responsiveness as Individual Responsibility**

All six participants consistently described cultural responsiveness as a responsibility they personally carried rather than a shared institutional commitment. This

pattern reflects findings in recent research on invisible cultural labor, wherein BIPOC counselors are often expected to serve as the informal cultural interpreter, advocates, and educators within predominantly White systems (Biang et al., 2024; Bray et al., 2025). Participants reported that multidisciplinary teams frequently relied on them to identify cultural concerns, adjust treatment expectations, and bridge gaps between standardized ED protocols and clients' lived realities. Rather than being supported through formal training, team-wide accountability, or organizational policy, cultural responsiveness was often treated as an additional responsibility added onto their clinical role. Christina's experience highlighted how this burden often emerged through both cultural advocacy and the need to repeatedly justify culturally informed clinical judgment:

I often had to educate both families and team members. Treatment felt standardized for White patients, and I had to advocate for flexibility. I also encountered barriers related to language access. Interpretation services were limited, time-consuming, and emotionally taxing for families. As a Hispanic therapist who can pass as White, I recognize my privilege. But I still felt voiceless at times. My cultural considerations were questioned or minimized. One example involved a Spanish family. Spanish varies widely by region, and communication style matters. I explained this to the team, but it was dismissed as unnecessary.

Christina's statement illustrated how cultural responsiveness was not only positioned as her responsibility but also treated as optional or secondary within clinical decision-making. Her description demonstrates that even when cultural considerations were raised thoughtfully and clinically, they were not consistently validated or integrated

into team planning. Additionally, her emphasis on language access reveals how structural limitations, such as limited interpretation services and inefficient workflows, created additional emotional and logistical burdens for both families and for the counselors advocating for them. Joya shared,

When I entered the treatment center, the training wasn't very robust. It was more guideline-based, this is how we treat eating disorders. But there wasn't enough attention to tailoring treatment for different cultural groups. I had to teach myself how to navigate cultural considerations. I relied on my own cultural competence to determine what felt clinically appropriate. That didn't feel fair. I was figuring things out on my own, while other clinicians may not have felt the same responsibility to do so.

Joya's account reinforces the pattern that culturally responsive practice was often learned through self-direction rather than through structured institutional training or shared team responsibility. Her description highlights the inequity of being expected to fill systemic gaps through personal knowledge and emotional labor, while other clinicians could rely on standardized protocols without confronting cultural limitations. This dynamic strengthened the theme that cultural responsiveness was not embedded into the organizational culture of ED treatment, but instead dependent on individual clinicians' willingness and ability to sustain the burden. Tonya stated,

With Indian patients, I understood the foods and became more involved with dietitians to help build appropriate meal plans. In my community, doctors' opinions often carry more weight, so I learned that the MD needed to be more

involved in later stages of treatment to help families engage. Mental health stigma is very real in my community. A lot of my role became education, reinforcing information with families and encouraging the team to do the same. I definitely spent more time with BIPOC families than with others.

Tonya's statement demonstrates how participants leveraged cultural knowledge not only to support clients directly but also to shape team strategies and improve treatment engagement. Her account also reveals a recurring expectation that BIPOC counselors would provide additional education, mediation, and relational support for families, work that required additional time and emotional energy beyond standard clinical responsibilities. Taken together, these findings indicate that culturally responsive ED care was frequently operationalized through the individualized efforts of BIPOC counselors rather than implemented through consistent multidisciplinary infrastructure, training, or policy. This meaning structure informed the final subtheme: reflexivity and unlearning cultural conditioning.

#### **Subtheme 5a: Reflexivity and Unlearning Cultural Conditioning**

Preparedness was described as an ongoing process requiring reflexivity, humility, and critical examination of internalized cultural beliefs. Five participants emphasized that providing culturally responsive ED care required them to actively “unlearn” messages about food, body image, respect, and worth that were shaped by family and cultural conditioning. This reflexive work was not presented as optional but as clinically necessary to avoid unintentionally reinforcing ED behaviors or misunderstandings across cultural contexts. Participants also described preparedness as dynamic strengthening

through experience while remaining incomplete when working with unfamiliar cultural groups or identities. Overall, reflexivity functioned as both a protective clinical practice and a professional responsibility that supported culturally responsive treatment planning and alliance building. To illustrate how reflexivity operated in practice, participants described moments when they recognized their own cultural conditioning and how it influenced their clinical perspectives. Christina offered a detailed reflection on how early cultural messages about food shaped her learning process in ED work:

I would say the main thing I would like to consider, especially for BIPOC counselors in the world of eating disorders, is that we need to check ourselves and unlearn cultural stigmas and ways in which we were raised. A big one for me was seeing how in Mexico it is very obvious who has resources and who doesn't.

Because of that, I was always told, "Finish all your food. It doesn't matter whether you're hungry or not, finish all your food." When I had clients with binge eating disorder, it was definitely something I had to check myself and unlearn, and ask, "Wait, what are they presenting with, and how is that affecting them?" It was important for me to check myself and ask what background beliefs I learned through my culture that could be contributing to eating disorder behaviors.

Christina's reflection highlights how cultural values such as respect, scarcity awareness, and family expectations can shape eating-related beliefs that later require intentional examination in clinical work. Her narrative also demonstrates that reflexivity involved recognizing how culturally normative practices can take on a different meanings within the context of ED pathology. Through this process, Christina described developing

greater awareness of how her own cultural background could influence her interpretation of clients' behaviors and treatment needs. Similarly, other participants described learning that their assumptions about who is affected by EDs required reconsideration early in their professional development. Zuri shared,

I don't think in the beginning I realized how much BIPOC patients were affected by eating disorder until you really get into it. I had a wake-up call about how many BIPOC patients suffer from eating disorders. On the outside looking in, you wouldn't think it would be as problematic in the BIPOC community, but it opened my eyes. I didn't feel trained. I didn't feel like I had enough to support them, and I was also new to eating disorders, so it was a completely different ballgame. In the beginning, there was definitely a deficit on my end in training. At the same time, because I can connect with patients who look like me, I had representation coming into the therapy space. That helped with building relationships, creating safety and security, and establishing therapeutic rapport. It helped establish baseline therapy care, but I was definitely at a deficit in the beginning.

Zuri's description reflects reflexivity as an awakening process, recognizing both the prevalence of EDs in BIPOC communities and the professional preparation gap needed to support these clients effectively. Her narrative also reinforces that representation can strengthen therapeutic relationships; however, representation alone does not replace the need for structured training, supervision, and cultural humility. Participants emphasized that reflexivity required acknowledging limitations while

continuing to build competence through learning, consultation, and engagement with clients' lived experiences. Cheryl added,

I feel prepared to work with many BIPOC clients, but I also feel unprepared when working with populations I see less often. For example, I recently received a Native American patient. I don't have much experience working with Native American clients with eating disorders. The same can be true for some Asian populations. There are cultural factors like stigma around therapy that I'm still learning about. I rely heavily on listening to patients, learning from them, doing my own research, and bringing cases to supervision. Patients are the best narrators of their own culture. We don't know everything as therapists, and we shouldn't pretend to.

Cheryl's statement illustrates how reflexivity extended beyond internal reflection to include deliberate professional practices such as consultation, supervision, and ongoing cultural learning. Her emphasis on patients as "the best narrators of their own culture" reinforce reflexivity as a stance of humility that helps guard against cultural assumptions while strengthening therapeutic alliance and culturally responsive treatment engagement.

### **Results Synthesis**

Across participant interviews, five essential themes emerged that captured shared meaning structures shaping the lived experiences of BIPOC counselors providing culturally responsive care to BIPOC clients with EDs while collaborating within multidisciplinary treatment teams. Collectively, participants described entering ED treatment settings with minimal formal education and limited preparation for culturally

responsive ED intervention. Instead, participants emphasized that competence developed primarily through immersion, requiring supervision, self-directed learning, continuing education, and trail-and-error practice within real-time clinical environments.

Participants' narratives also emphasized the need for structural reform, including ED-specific coursework, applied cultural case training, anti-racism and DEI-informed clinical education, and meaningful representation of BIPOC clinicians within leadership and decision-making roles.

In addition to preparation gaps, participants described standardized ED treatment models as frequently prioritizing diagnostic compliance, weight thresholds, and protocol-based goals over personhood, cultural context, and relational realities for BIPOC clients and families. Participants further described working within predominantly White treatment environments where their perspectives were often minimized, creating experiences of marginalization that shaped professional voice and psychological safety. Within these contexts, advocacy emerged as necessary but emotionally and professionally risky, particularly when participants challenged culturally dismissive assumptions or advocated for culturally relevant care needs. Finally, participants described cultural responsiveness as an individualized responsibility disproportionately carried by BIPOC counselors rather than embedded into multidisciplinary infrastructure, with reflexivity and the unlearning of cultural conditioning functions as clinically necessary practices for sustaining culturally responsive care. Together, these findings highlight the systemic tensions experienced by BIPOC counselors navigating ED

treatment environments where cultural responsiveness was inconsistently operationalized and often dependent on individual labor.

### **Discrepant Cases**

Although thematic consistency across interviews was strong, several variations emerged among participants' experiences. One participant reported brief exposure to ED content during graduate training; however, this exposure was described as insufficient for clinical preparedness and ultimately reinforced the broader theme of inadequate education. Additionally, while Christina and Tonya described overt experiences of silencing during multidisciplinary discussions, Ebony and Cheryl described subtler forms of self-monitoring and adaptation within predominantly White professional environments. These variations refined the boundaries of the themes without contradicting the essential structure of the phenomenon.

### **Summary**

In Chapter 4, I presented the findings of this descriptive, transcendental phenomenological study exploring the lived experiences of BIPOC counselors providing culturally responsive care to BIPOC clients with EDs while collaborating on multidisciplinary treatment teams in predominantly White clinical environments. Using Giorgi's (2009) descriptive phenomenological method, I analyzed interview data to identify the essential meaning structure of participants' experiences, including how they entered the ED field, navigated diagnosis-centered treatment cultures, and encountered marginalization within professional environments. Participants described how ED treatment models often prioritized weight restoration, compliance, and standardized

protocols in ways that minimized cultural context, family systems, and language needs. Across themes, participants also described experiences of being questioned, minimized, or silenced when raising cultural considerations, which contributed to professional isolation and emotional strain.

The finding further demonstrated that participants' preparedness to provide culturally responsive care was not rooted in formal graduate training but instead developed through immersion, supervision, self-directed learning, and ongoing reflexivity. Participants described cultural responsiveness as a personal responsibility rather than an organizational priority, frequently requiring them to advocate for culturally appropriate food options, flexibility in treatment plans, representation, and family inclusion, often at emotional and professional risk. As the themes progressed toward future-facing recommendations, participants emphasized the need for structural reform through improved education, anti-racism training, culturally responsive supervision, institutional accountability, and increased representation across leadership and multidisciplinary teams. Together, these findings clarify that culturally responsive ED care is shaped not only by individual clinical competence but also by systemic conditions that either support or constrain equity-oriented practice within ED treatment environments. In Chapter 5, I discuss these findings in relation to existing literature and conceptual frameworks, interpret the implications for counseling practice and counselor education, and present recommendations for future research and systemic reform within the ED field.

## Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this descriptive transcendental phenomenological qualitative study was to explore and describe the lived experiences of BIPOC counselors regarding their preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs, particularly within the context of multidisciplinary treatment teams. This study was conducted to address a gap in the ED counseling literature, which has historically emphasized predominantly White clinician perspectives and Eurocentric treatment models despite increased ED prevalence among diverse populations (Biang et al., 2024; Halbeisen et al., 2022; Labarta & Bendit, 2024; Sonnevile & Lipson, 2018). The current study was guided by the central research question: What are the lived experiences of BIPOC counselors who collaborate with multidisciplinary teams providing culturally responsive care to BIPOC clients diagnosed with eating disorders? The subquestion as the following: How do BIPOC counselors describe their level of preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs as part of a multidisciplinary treatment team?

Six fully licensed BIPOC counselors with a minimum of 1 year of experience in ED treatment settings participated in semistructured interviews. Data analysis followed Giorgi's (2009) descriptive phenomenological method. Findings yielded five essential themes: (a) lack of education and training and the need for structural and educational change, (b) diagnosis prioritized over personhood, (c) marginalization in predominantly White spaces, (d) advocacy as emotional and professional risk, and (e) cultural responsiveness as individual responsibility, with subthemes including nontraditional

entry into ED field, learning through immersion, a call for structural change and representation, and reflexivity and unlearning cultural conditioning. Across participant interviews, preparedness was consistently described not as a product of graduate training but as something built through immersion, self-directed learning, supervision, lived experience, and ongoing reflexive practice. Additionally, participants described culturally responsive ED care as structurally limited by standardized recovery models, race-based silencing within multidisciplinary team dynamics, and institutional reliance on BIPOC counselors to carry cultural labor in the absence of organizational infrastructure.

Overall, this study contributes to counseling scholarship by centering the voices of BIPOC ED counselors and clarifying how their professional preparedness, team participation, and culturally responsive practices are shaped not only by educational gaps but also by systemic inequities within multidisciplinary ED treatment culture. The findings provide a foundation for improving counselor education, supervision practices, multidisciplinary accountability, and culturally responsive treatment infrastructure in ED settings while remaining anchored in the lived experiences described by the participants.

### **Interpretation of the Findings**

The findings of this study confirm and extend the literature reviewed in Chapter 2 regarding the current state of ED treatment, counselor preparedness, and the realities of providing culturally responsive care within predominantly White clinical spaces. Across participant narratives, the essential meaning structure revealed a repeated pattern: BIPOC counselors frequently entered ED work without adequate preparation and were required to develop clinical competence while simultaneously managing institutional Whiteness,

biomedical dominance, and cultural invalidation within multidisciplinary teams. These themes align with existing research documenting (a) the lack of ED education in training programs (Labarta et al., 2023; Levitt, 2006), (b) underrepresentation and marginalization of BIPOC clinicians in the ED workforce (Biang et al., 2024; Halbeisen et al., 2022; Jennings-Mathis et al., 2020), and (c) the urgent need for culturally responsive practices within ED assessment and treatment (Labarta & Bendit, 2024; Perez et al., 2021; Sonnevile & Lipson, 2018; Uri et al., 2021). However, this study extends the existing knowledge base by revealing how these dynamics operate within multidisciplinary team environments, where BIPOC counselors simultaneously navigate professional collaboration and racial disparities embedded in clinical hierarchies.

Participants' accounts extended beyond descriptions of training deficiencies or general workplace challenges. Instead, their narratives revealed a deeper structure of experience in which culturally responsive ED care was often positioned as an individual responsibility rather than an institutional standard. Although the counseling profession has increasingly emphasized multicultural competence and social justice frameworks (Ratts et al., 2016; Singh et al., 2020), participants described treatment systems in which culturally responsive care was inconsistently valued and, at times, dismissed. These findings support that culturally responsive ED treatment is shaped not only by individual clinical competence but also by structural factors, professional hierarchies, and broader institutional norms. Consequently, the findings extend the literature by demonstrating that culturally responsive ED care cannot be fully understood without examining

multidisciplinary team dynamics and the lived experiences of the BIPOC counselors working within these environments.

### **Summary of Key Findings**

Five essential themes and associated subthemes emerged as shared meaning structures across participants' narratives. First, participants consistently described a lack of education and training related to EDs and culturally responsive ED care, as well as a need for structural and educational change. Within Theme 1, participants described entering the ED field through nontraditional pathways, developing competence through immersive learning experiences, and advocating for greater structural change and representation within training programs and leadership roles. Second, participants described treatment environments in which diagnosis was prioritized over personhood, with standardized protocols and biomedical indicators often taking precedence over cultural, relational, and contextual realities. Third, participants described experiences of marginalization within predominantly White clinical spaces, including being silenced, experiencing heightened scrutiny, engaging in self-monitoring, and encountering limited representation. Fourth, participants described advocacy as both an emotional and profession risk, characterizing it as necessary for client well-being but also taxing, persistent, and at times requiring escalation within clinical hierarchies. Fifth, participants described cultural responsiveness as an individual responsibility rather than a shared institutional practice. Within Theme 5, participants also described reflexivity and the process of unlearning cultural conditioning as ongoing requirements for providing culturally responsive ED care.

Across themes, the essence of the phenomenon reflected a core structural tension. Participants were expected to provide culturally responsive care for BIPOC clients within multidisciplinary systems that often treated standardized recovery models as universally applicable. At the same time, cultural responsiveness was inconsistently operationalized and frequently depended on the individualized labor of BIPOC clinicians.

### **Interpreting Findings Within the Theoretical Foundation**

The interpretation of these findings is presented in alignment with the descriptive commitments of transcendental phenomenology. Husserl's (1962) concept of intentionality informs an understanding of participants' accounts as meaning-laden experiences shaped through consciousness, relational positioning, and professional identity. Giorgi's (2009) methodological framework further requires that findings remain grounded in participants' descriptions and not extend beyond what was explicitly reported. Accordingly, the interpretations that follow remain within the boundaries of the data and are situated in dialogue with the peer-reviewed literature presented in Chapter 2. This approach allows for the identification of areas of confirmation, disconfirmation, and extension of knowledge within the counseling discipline and the ED field.

### **Theme 1: Lack of Education and Training and the Need for Structural and Educational Change**

All participants described limited or absent ED education in graduate training. This finding strongly confirms existing literature identifying widespread deficits in ED instruction across training programs (Irvine & Labart, 2024; Labarta et al., 2023; Levitt, 2006). Labarta et al. (2023) reported that many clinicians received minimal instruction

(five hours or less), had limited coursework on ED treatment, and reported persistent feelings of incompetence when treating EDs. Participants in the current study provided lived experience confirmation of these findings, describing how ED content was either absent from their training or briefly mentioned and framed as peripheral to core counseling competencies.

This theme also confirms broader concerns that inadequate training may contribute to ethical risk in clinical practice. Effective ED treatment requires knowledge of medical risk, diagnostic complexity, and cultural variation in symptom presentation (Perez et al., 2021; Uri et al., 2021). Participants described entering the field without this foundational knowledge, suggesting that counselor education programs may unintentionally contribute to inequitable care when future counselors are not adequately prepared to identify ED presentations among BIPOC clients. This finding directly connects to the literature in Chapter 2 regarding the underdiagnosis and misdiagnosis of EDs among BIPOC populations. For example, Sonnevile and Lipson (2018) reported major disparities in diagnosis rates among BIPOC college students, and Perez et al. (2021) found culturally distinct symptom presentations that do not align with Eurocentric diagnostic assumptions. Participants' accounts therefore support the argument that educational gaps are not neutral; rather, they may reinforce diagnostic and treatment inequities.

This study extends knowledge by clarifying how training deficits are experienced by BIPOC counselors as an inequitable professional burden. Participants did not simply describe feeling unprepared; they described being expected to develop competence

quickly while also navigating workplace marginalization and performing cultural labor within multidisciplinary teams. Therefore, inadequate training does not operate in isolation. Instead, it intersects with systemic workplace bias, limited mentorship opportunities, and underrepresentation in leadership roles, producing a combined preparedness deficit.

From a phenomenological perspective, this finding reflects Husserl's emphasis on returning "to the things themselves" (Husserl, 1962, p. 35). Participants' lived experiences suggested that educational institutions do not consistently present ED care as an area requiring purposeful training and preparation. Accordingly, the field may benefit from reconsidering how counselor education programs cultivate awareness and competence related to ED treatment, particularly when working with diverse populations.

***Subtheme 1a: Nontraditional Entry Into the ED Field***

The finding that all six participants entered the ED field through nontraditional and often circumstantial pathways extends current workforce knowledge by clarifying how BIPOC counselors may be excluded from intentional pipelines into ED specialization (Biang et al., 2024; Jennings-Mathis et al., 2020). Participants consistently described entering the ED field unintentionally, commonly due to the job availability, clinical hour requirements, or shifting career circumstances. This finding confirms broader workforce concerns documented in the literature suggesting that ED training and specialization are often not systematically emphasized within counseling education programs (Labarta et al., 2023; Irvine & Labarta, 2024). When ED content is absent from training curricula, counselors may be less likely to intentionally pursue ED work as a

specialization, reinforcing delayed entry and inconsistent preparedness. This aligns with research suggesting that EDs are frequently treated as “niche” content despite the high likelihood that clinicians will encounter ED presentations throughout their careers (Harrop et al., 2023; Thompson-Brenner et al., 2012).

However, the findings of this study extend the literature by suggesting that nontraditional entry into ED work may have distinct implications for BIPOC counselors. Participants described that EDs were not visible in their communities or educational contexts as conditions affecting BIPOC populations. This narrative supports scholarship challenging the longstanding “skinny, White, affluent, girls” stereotype and underscores how cultural assumptions influence both education and workforce development (Biang et al., 2024; Halbeisen et al., 2022; Sonnevile & Lipson, 2018). When EDs are not presented as relevant to BIPOC communities, BIPOC trainees may encounter fewer structured pathways into ED clinical settings.

Consequently, entry into ED work becomes less likely to be supported by purposeful mentorship, preparation, or culturally responsive training, further reinforcing systemic inequities in workforce representation. From a phenomenological standpoint, nontraditional entry functioned as an experiential starting point shaping how participants later understood preparedness and professional identity. In Husserlian terms, the intentional object of consciousness (Husserl, 1962) was not initially “ED specialization”, but rather employment opportunities or general clinical engagement. As participants became immersed in ED work, their meaning-making evolved as they encountered the severity of ED pathology and the systemic absence of culturally responsive care.

This progression highlights the phenomenon as an unfolding process of professional consciousness rather than a fixed or static condition. The subtheme therefore extends the literature reviewed in Chapter 2 by suggesting that inadequate preparation reflects not only curricular limitations but also structural pipeline barriers. For many BIPOC counselors, entry into ED work occurred through circumstance rather than an intentionally cultivated professional trajectory, increasing early-career vulnerability and reliance on self-directed learning within demanding clinical environments.

As participants moved beyond their initial entry into ED settings, nontraditional pathways gave way to sustained immersion in the clinical environments. What began as circumstantial employment evolved into continuous exposure to the intensity of ED care, requiring participants to learn through direct engagement rather than formal preparation. This shift from entry to immersion marked a critical phase in which professional understanding, clinical skill development, and cultural awareness were shaped in real time through daily practice.

***Subtheme 1b: Learning Through Immersion***

Participants described immersion as the primary pathway through which competence was developed, relying on supervision, continuing education, and trial-and-error rather than structured graduate preparation. This finding confirms literature documenting that counselors frequently pursue additional training independently due to limited ED coursework in their academic programs (Biang et al., 2024; Labarta et al., 2023). Biang et al. (2024) similarly reported that counselors of color frequently pursued continuing education postgraduation due insufficient training in their graduate programs.

However, participants' accounts extend the discipline by revealing that immersion involved more than clinical learning. Participants described learning ED treatment while simultaneously navigating culturally invalidating team norms and White-dominant assumptions about food, family involvement, and recovery. This finding aligns with literature critiquing Eurocentric treatment paradigms and advocating for decolonizing approaches to training and care (Shell et al., 2022; Smith et al., 2021). The study therefore extends existing knowledge by showing how immersion becomes an inequitable professional requirement. BIPOC counselors are often expected to develop clinical competence while simultaneously performing cultural translation within treatment teams, a dynamic that may increase emotional labor and professional strain.

As participants remained immersed in ED treatment settings, their accounts reflected an increasing awareness of systemic features extending beyond clinical skill development. Through ongoing participation in multidisciplinary teams, participants began to notice patterns they described as missing, uneven, or individualizing, including limited culturally responsive resources, lack of representation, and expectations that they personally address cultural concerns. Over time, their narratives shifted from describing adaptation to articulating a need for systemic change.

***Subtheme 1c: A Call for Structural Change and Representation***

Participants called for structural change beginning at entry into the field, including earlier education, applied case-based cultural training, anti-racism instruction, and meaningful representation in leadership and decision-making. This finding confirms the literature reviewed in Chapter 2 arguing that multicultural competence in theory is

insufficient without operational and systemic reform (Ratts et al., 2016; Shell et al., 2022; Singh et al., 2020; Smith et al., 2021). Participants emphasized that culturally responsive tools and supports should be available at the point of entry into the field rather than something counselors must locate only after years of navigating professional isolation and marginalization. This aligns with the literature suggesting that culturally responsive frameworks and relational safety strengthen client engagement and therapeutic alliance (Labarta & Bendit, 2024) and with scholarship highlighting the need to address systemic conditions that contributing to burnout and turnover among BIPOC clinicians (Jennings-Mathis et al., 2020; Shell et al., 2022).

This theme extends existing knowledge by positioning representation as more than a workforce diversity goal. Instead, representation emerged as a key contributor to clinical effectiveness (Biang et al., 2024; Jennings-Mathis et al., 2020). Participants described how representation promotes inclusion, reduces professional disconnection, supports counselor retention, and strengthens culturally responsive decision-making within multidisciplinary teams. Therefore, representation functions not only as an equity initiative but also as a clinical priority that directly enhances the quality of care.

As participants described their calls for structural change and increased representation, their accounts also shifted toward how care was organized and enacted in everyday clinical practice. Participants frequently described treatment environments in which attention centered on diagnosis, treatment plans, or protocols before attention was given to the person receiving care or the counselor providing it. Within these descriptions, participants noted moments in which cultural context, relational meaning,

and lived experience felt secondary or absent. These observations emerged through participants' reflections on routine clinical interactions rather than abstract critique, shaping how they understood the clinical culture in which they worked. The following theme presents how participants experienced and described this dynamic as diagnosis being prioritized over personhood.

### **Theme 2: Diagnosis Prioritized Over Personhood**

Across participants' accounts, a recurring description involved treatment environments in which diagnostic categories and standardized recovery expectations guided decision-making more prominently than individual context. Participants described settings where clinical conversations often centered on symptoms, behaviors, and treatment compliance, while aspects of identity such as culture, family meaning, and lived experience were addressed less consistently. Several participants reflected that this emphasis influenced not only how clients were understood but also how counselors were expected to engage in care. These descriptions emerged through participants' observations of treatment planning meetings, documentation practices, and everyday interactions with clients and multidisciplinary teams.

Theme 2 confirms the literature reviewed in Chapter 2 critiquing the biomedical dominance of ED treatment systems and the risks associated with applying standardized treatment protocols as though they are culturally neutral (Halbeisen et al., 2022; Kazdin et al., 2017; Labarta et al., 2023). Participants described multidisciplinary environments where weight markers, diagnosis labels, and compliance expectations were treated as primary indicators of treatment progress, while cultural context and personhood were

often minimized. Participants highlighted that culturally rooted food practices, family structures, and language needs were often interpreted as barriers to treatment or as indicators of noncompliance rather than as meaningful aspects of clients' lived experiences.

This theme also disconfirms the assumption that multidisciplinary team-based care is inherently holistic or culturally responsive. Although existing literature highlights the potential effectiveness of multidisciplinary treatment models (Maia et al., 2024; Woodruff et al., 2020), participants' accounts suggest that such structures may reproduce inequities when cultural considerations are not consistently integrated across disciplines or when biomedical authority is prioritized over relational and contextual understanding. Participants' narratives further suggest that team-based care does not necessarily translate into person-centered care, particularly for BIPOC clients whose cultural foods, language use, family dynamics, or stigma-related concerns may be misunderstood when interpreted outside of cultural context.

This finding extends existing literature by providing lived accounts of how diagnostic reductionism operates within real-world multidisciplinary treatment settings. Participants described how standardized recovery models were often treated as universally applicable, despite being grounded in research samples that have historically underrepresented BIPOC populations (Strauch et al., 2023). One participant, in particular, described experiencing tension when clinical decisions were justified through research-based outcome arguments that did not adequately reflect BIPOC representation in the evidence base. Taken together, these findings help bridge the gap between

scholarship on exclusion in research samples and the clinical consequences of applying those findings across diverse cultural contexts (Halbeisen et al., 2022; Strauch et al., 2023).

As participants described treatment environments in which diagnostic frameworks and standardized models organized care, their accounts also reflected how these practices were embedded within broader organizational and cultural contexts. Several participants noted that expectations surrounding neutrality, professionalism, and standard clinical practice often reflected norms associated with predominantly White clinical spaces. Within these settings, participants described moments in which cultural perspectives, communication styles, and relational approaches felt less visible or less valued. These experiences shaped how participants understood not only the delivery of client care but also their own professional positioning within treatment systems. The following theme explores how participants described experiences of marginalization while working in predominantly White ED treatment environments.

### **Theme 3: Marginalization in Predominantly White Spaces**

Participants described ED treatment settings as environments where Whiteness often functioned as an unspoken norm shaping clinical practice, team interactions, and professional expectations. Within these environments, participants recounted experiences of being one of few or sometimes the only BIPOC clinicians on their teams. They described navigating settings in which cultural perspectives were not routinely invited into clinical discussions and where raising concerns related to race, culture, or identity was sometimes met with discomfort, dismissal, or silence. These accounts were not

described as isolated incidents but rather as recurring features of participants' everyday professional experiences within ED treatment systems.

Theme 3 confirms the literature documenting isolation, silencing, and racialized stress among BIPOC counselors working in predominantly White clinical settings (Biang et al., 2024; Halbeisen et al., 2022; Jennings-Mathis et al., 2020). Participants described feeling voiceless, scrutinized, and professionally isolated within these settings. They also reported engaging in self-monitoring and assimilation behaviors, which aligns with existing research suggesting that BIPOC clinicians often adjust their language, appearance, and emotional expression to preserve safety, credibility, and professional standing within predominantly White settings (Choe et al., 2024). Participants further described limited representation in leadership positions, heightened scrutiny when advocating for BIPOC clients, and the need to carefully navigate workplace norms. These accounts align with literature describing racial invalidation, microaggressions, and the emotional toll associated with working within White-dominant professional cultures (Shell et al., 2022; Smith et al., 2021).

This study expands existing literature by identifying how marginalization may occur within multidisciplinary decision-making processes, not solely through interpersonal interactions. Participants described instances in which their input, particularly when advocating for culturally responsive care for BIPOC clients, was more likely to be resisted, minimized, or disregarded than similarly advocacy efforts made on behalf of White clients. This finding extends current scholarship by highlighting a pathway through which marginalization may influence clinical outcomes. When BIPOC

counselors' cultural knowledge and advocacy are dismissed, culturally responsive treatment approaches are less likely to be meaningfully integrated into multidisciplinary treatment planning, potentially limiting both the effectiveness and equity of care.

As participants described experiences of marginalization within predominantly White treatment environments, their accounts also reflected how these contexts shaped decisions about whether and how to speak up. Several participants described carefully weighing when to raise cultural concerns, question clinical decisions, or advocate for clients, particularly in environments where they already felt invisible or professionally isolated. These descriptions highlighted moments in which advocacy was not experienced as a routine professional responsibility but rather as an action requiring deliberate consideration of relational dynamics and potential consequences. The following theme explores how participants described advocacy as carrying emotional and professional risk within ED treatment systems.

#### **Theme 4: Advocacy as Emotional and Professional Risk**

Participants described advocacy for culturally responsive care as an experience that often involved significant emotional labor and professional vulnerability. Rather than feeling supported by organizational structures, participants spoke about advocacy as something they undertook individually, frequently without clear guidance or institutional protection. They described concerns about being perceived as difficult, overly sensitive, or biased when raising cultural issues, as well as uncertainty about how such advocacy might affect relationships with colleagues or supervisors. These accounts illustrate how

advocacy emerged as a meaningful yet potentially risky aspect of participants' professional experiences within ED treatment settings.

Theme 4 confirms literature suggesting that BIPOC counselors frequently carry an additional advocacy burden within predominantly White systems, including educating colleagues and advocating for culturally responsive adjustments that others may not prioritize (Biang et al., 2024; Bray et al., 2025; Jennings-Mathis et al., 2020). Participants described escalating concerns to leadership, repeatedly advocating for client needs, and navigating fears of being perceived as confrontational or difficult. They also emphasized that advocacy remained necessary to protect the dignity, engagement, and well-being of BIPOC clients. Participants described advocating for culturally relevant foods, language considerations, and culturally specific care needs that were often overlooked within standardized treatment approaches. These findings align with literature suggesting that culturally responsive practice frequently requires sustained effort from clinicians working within systems that do not distribute responsibility for cultural responsiveness equitably (Shell et al., 2022; Singh et al., 2020).

The findings also extend the literature by clarifying the scope of what advocacy entails within ED treatment settings. Participants described advocacy not only for commonly discussed concerns such as cultural food practices and language access but also for culturally specific self-care needs, such as haircare, that colleagues sometimes dismissed as irrelevant or "nonclinical". Participants emphasized, however, that these needs were closely connected to clients' dignity, comfort, and emotional stability during treatment. This finding broadens how culturally responsive ED care may be

conceptualized, suggesting it must account for clients' everyday cultural realities rather than focusing solely on symptom centered adaptations to treatment protocols.

As participants described advocacy as emotionally and professionally risky, their accounts also revealed how responsibility for culturally responsive care was unevenly distributed across treatment systems. Several participants described advocating repeatedly for similar concerns without corresponding changes at the organizational or team level. Over time, participants described a growing sense that cultural responsiveness was treated less as a shared institutional responsibility and more as an expectation placed on individual clinicians. These descriptions marked a shift from isolated moments of advocacy toward an ongoing expectation of personal responsibility. The following theme explores how participants experienced cultural responsiveness as an individual obligation within ED treatment settings.

#### **Theme 5: Cultural Responsiveness as Individual Responsibility**

Participants described cultural responsiveness as work that frequently fell to them personally rather than being embedded within treatment models or institutional practices. Many participants reported being expected to educate colleagues, adapt treatment approaches, or address cultural considerations without formal support, training, or recognition. They described this responsibility as persistent and often invisible, embedded within daily clinical decision-making and team interactions. These accounts reflect how cultural responsiveness was experienced not as an organizational standard but as individualized labor carried alongside participants' primary clinical roles.

Theme 5 strongly confirms literature suggesting that culturally responsive care is often operationalized through individual clinician labor rather than formalized institutional infrastructure (Biang et al., 2024; Shell et al., 2022; Smith et al., 2021). Participants reported being relied upon to identify cultural concerns, translate treatment expectations, and bridge gaps between standardized ED protocols and clients' lived realities. These experiences reflect the "invisible labor" described in Chapter 2, in which BIPOC clinicians are positioned as informal cultural interpreters without corresponding institutional support or shared accountability (Biang et al., 2024; Jennings-Mathis et al., 2020).

From an interpretive standpoint, this theme disconfirms the assumption that organizational diversity, equity, and inclusion (DEI) language naturally results in culturally responsive clinical infrastructure. Even participants employed in settings that publicly emphasized inclusion described ongoing experiences of invalidation or dismissal when cultural concerns were raised. This finding highlights a structural disconnect between multicultural values and day-to-day clinical practices within some ED treatment environments.

The theme further extends existing knowledge by highlighting how responsibility for cultural responsiveness operates within multidisciplinary systems rather than solely within counseling roles. Participants described dietitians, medical and psychiatric providers often struggling to translate treatment practices into culturally relevant frameworks, implicitly relying on BIPOC counselors to bridge these gaps. This finding contributes to the ED literature by demonstrating that culturally responsive care cannot be

confined to therapy sessions alone; it must be integrated across multidisciplinary treatment systems. When responsibility for cultural responsiveness is carried by a single discipline, inequities in care may persist. This finding extends the call in Chapter 2 to move beyond general multicultural instruction toward operational reforms, including supervisor training, interdisciplinary accountability, and increased leadership representation (Shell et al., 2022; Singh et al., 2020).

As participants described cultural responsiveness as work largely carried at the individual level, their accounts also reflected how this responsibility prompted ongoing self-examination. Several participants described needing to pause, reflect, and reconsider their own assumptions while working within ED treatment settings. These reflections often emerged through clinical encounters, team interactions, and moments of tension rather than through formal instruction. Within this context, reflexivity became a central process through which participants made sense of their professional roles and navigated cultural responsibility in the absence of shared structural guidance. The following subtheme explores how participants described engaging in reflexivity and unlearning cultural conditioning as part of their professional experience.

Participants described reflexivity as an active and ongoing process through which they examined how cultural messages, professional training, and dominant clinical norms shaped their practice. Several participants described recognizing internalized assumptions related to food, body norms, health, and professionalism, noting that these assumptions often reflected broader cultural conditioning rather than their own values or lived experiences. Through continued reflection, participants described efforts to unlearn these

patterns to provide care that aligned more closely with clients' cultural contexts. These accounts highlight reflexivity as a central component of how participants navigated culturally responsive practice in their daily clinical work.

Participants described reflexivity and the process of unlearning cultural conditioning as essential to ethical and culturally responsive ED treatment. These findings align with literature emphasizing humility, self-awareness, and attention to sociocultural messages about bodies and food (Labarta & Bendit, 2024; Lertora et al., 2020; Shell et al., 2022). Participants described becoming increasingly aware of internalized beliefs shaped by experiences of scarcity, dominant body ideals, and cultural stigma. They then described deliberately examining how these beliefs might influence their clinical assumptions, interpretations, and interventions.

The subtheme also disconfirms the assumption that shared racial identity alone ensures full preparedness for culturally responsive care. Participants described feeling well prepared to work with some cultural groups while recognizing the need for continued learning when working with others. These reflections highlight the importance of ongoing education, consultation, and culturally humble practice. This finding aligns with professional ethical standards emphasizing that competence is developmental and that counselors must seek supervision and education when working across cultural differences (ACA, 2014).

This subtheme extends knowledge by demonstrating that reflexivity functions not only as a professional value but also as a concrete preparedness process. Many participants described entering ED work feeling unprepared, and reflexivity served as a

corrective process that strengthened their ability to provide culturally responsive treatment. Therefore, the findings provide empirical support for conceptual arguments that culturally responsive competence is developmental and strengthened through continuous reflection and professional growth rather than existing as a fixed or static skill set (Ratts et al., 2016; Singh et al., 2020).

### **Synthesis of Interpretation**

Overall, the findings strongly confirm the literature reviewed in Chapter 2 regarding inadequate ED training, the marginalization of BIPOC counselors within White dominant clinical spaces, and the urgent need for systemic reform in ED treatment and counselor education (Biang et al., 2024; Irvine & Labarta, 2024; Labarta et al., 2023; Shell et al., 2022). The findings extend existing knowledge by demonstrating how these issues converge within multidisciplinary team contexts, where culturally responsive care is frequently operationalized through individual labor rather than shared institutional infrastructure. The findings also partially disconfirm optimistic assumptions that multidisciplinary teams inherently produce holistic care or that generalized multicultural training sufficiently prepares counselors for culturally responsive ED treatment. Within the descriptive phenomenological framework, the essence of the phenomenon can be understood as BIPOC counselors practicing culturally responsive care within systems that often require them to simultaneously function as clinicians, cultural translators, and advocates while navigating diagnosis centered treatment norms and racialized workplace dynamics.

### **Limitations of the Study**

The limitations discussed below focus specifically on limitations to trustworthiness that arose from the execution of the study, consistent with qualitative standards for credibility, transferability, dependability, and confirmability (Burkholder et al., 2020; Ravitch & Carl, 2021). Identifying these limitations provides transparency regarding the methodological decisions and contextual factors that may have influenced the findings. Acknowledging these constraints also supports a balanced interpretation of the results and highlights areas for future research to further examine the phenomenon.

#### **Credibility Limitations**

Although credibility was strengthened through member checking, reflexive journaling, and use of verbatim participant quotations, credibility may have been constrained by the interview context and the sensitivity of the topic. Participants discussed experiences related to race, microaggressions, and professional marginalization within a relatively small specialty field. As a result, participants may have engaged in selective disclosure to protect professional relationships or avoid being identifiable through details of their experiences, even with pseudonyms and the omission of identifying information were used (see Burkholder et al., 2020). This limitation is particularly relevant given the small and interconnected nature of ED professional communities, which may increase the perceived risk of recognition.

Credibility may also have been impacted by the use of virtual interviews. Although Zoom facilitated accessibility and scheduling flexibility, virtual interviews can limit rapport-building, constrain observation of full-body nonverbal cues, and introduce

potential environmental distractions (Ravitch & Carl, 2021). Minor connectivity issues or audio disruptions, while not severe enough to terminate interviews, may have briefly interrupted the flow of conversation during emotionally complex discussions.

Additionally, because interviews occurred in participants' chosen environments, participants may have moderated their responses if privacy could not be fully ensured.

### **Transferability Limitations**

Transferability is inherently limited in phenomenological research because the goal is not statistical generalization but the provision of rich, thick description that allows readers to determine the applicability of findings to similar contexts (Burkholder et al., 2020). In this study, transferability may be limited by the sample's geographic concentration along the U.S. East Coast and by the participants' professional characteristics, including being fully licensed counselors with at least one year of experience working within multidisciplinary ED treatment settings. As a result, findings may not transfer to (a) counselors practicing in other geographic regions, (b) pre-licensed counselors or trainees, (c) professionals from other disciplines involved in ED treatment teams such as dietitians, physicians, or psychiatrists, or (d) clinical environments outside specialized ED treatment programs.

Additionally, the sample consisted entirely of women and included representation from Black/African American, Asian, and Hispanic identities. While this sample provided meaningful diversity of perspectives, it may not represent the full range of BIPOC counselor experiences, particularly those of Indigenous counselors or other racial and ethnic groups not represented in the sample. Further, the study focused on counselors

who had direct experience working with BIPOC clients diagnosed with EDs, which may limit transferability to settings where BIPOC client representation is limited due to organizational demographics.

### **Dependability Limitations**

Dependability was supported through the use of an audit trail, consistent research procedures, and the systematic application of Giorgi's phenomenological method. However, because the researcher served as the sole instrument for both data collection and analysis, dependability may be limited by the absence of multiple coders. Although phenomenological research does not require interrater reliability in the same manner as some qualitative approaches, the inclusion of secondary analyst could have provided additional audit support for meaning-unit segmentation and thematic clustering decisions (Burkholder et al., 2020; Ravitch & Carl, 2021).

Dependability may also have been influenced by the variability of participants' professional practice environments. Participants worked in a range of ED treatment settings with differing organizational cultures, treatment levels, and team structures. Although this variability strengthened the study's ability to identify shared meaning structures across contexts, it also suggests that multidisciplinary culturally responsive ED practice may manifest differently depending on contextual factors that were not the primary focus of this study. Because the study did not aim to compare treatment settings or quantify contextual differences, dependability is limited to the stability of themes across this dataset rather than across all possible ED treatment environments.

### **Confirmability Limitations**

Confirmability was supported through the use of bracketing, reflexive journaling, and grounding themes in participants' verbatim quotations. Nevertheless, confirmability may be influenced by the researcher's positionality and proximity to the phenomenon under study. The researcher's identity as a Black counselor with extensive experience in the ED field may increase the likelihood of resonance with participants' accounts. Although bracketing procedures were intentionally employed to reduce the imposition of assumptions (see Giorgi, 2009; Peoples, 2021), complete neutrality is not claimed within qualitative inquiry.

Confirmability may also be limited by the reliance on self-reported data. Participants provided retrospective accounts of their experiences, which may be influenced by memory recall, emotional salience, or the desire to present experiences within a coherent narrative structure. Although phenomenological research values participants' lived meanings and interpretations, this reliance on self-report means that findings reflect experiences as described by participants rather than experiences independently verified through additional data sources such as team meeting observations or organizational documents. The study prioritized participant safety and confidentiality, triangulation through workplace materials was not pursued and therefore represents a limitation to confirmability.

### **Summary of Limitations**

In summary, several limitations to trustworthiness arose from the execution of the study. These include (a) potential constraints on participant disclosure due to the small

size of the ED professional field and the sensitivity of the research topic, (b) limitations associated with virtual interviews related to nonverbal observation and privacy, (c) reliance on a single researcher for data analysis without a secondary coder or external audit, (d) sample characteristics related to geography, gender, and representation, and (e) reliance on self-reported experiences without additional triangulated data sources. These limitations should be considered when interpreting the findings and may inform future research seeking to further examine the experiences of BIPOC counselors working within ED treatment systems (Burkholder et al., 2020; Ravitch & Carl, 2021).

### **Recommendations**

Future research should expand this study by including a larger and more geographically diverse sample of BIPOC counselors working across varied ED treatment settings and levels of care to strengthen transferability and deepen understanding of contextual variation. Additional studies should include BIPOC clinicians from other disciplines within multidisciplinary teams (e.g., dietitians, physicians, psychiatrists) to examine how culturally responsive care is understood and operationalized across professional roles and team hierarchies. Researchers should also explore the experiences of BIPOC counselors at earlier career stages (e.g., trainees, associates, interns) to better understand pipeline barriers and preparedness during entry into the ED field.

Future studies may benefit from longitudinal designs that examine how immersion-based learning, advocacy burden, and professional marginalization influence counselor retention, burnout risk, and leadership trajectories over time (Shell et al., 2022). Researchers should also investigate structured supervision and training

interventions such as culturally responsive supervision models and applied cultural case training, to evaluate how institutional supports influence counselor preparedness and client engagement outcomes (Irvine et al., 2021; Labarta et al., 2023). Finally, future research should prioritize the inclusion of underrepresented BIPOC groups not represented in this sample, including Indigenous clinicians, to fully capture the diversity of professional experiences within ED care systems (Halbeisen et al., 2022).

### **Implications**

This study has implications for positive social change at multiple levels, including individual, family, organizational, and societal or policy levels. Participants described culturally responsive ED care as inseparable from the systemic conditions that shape access to care, treatment engagement, and the professional sustainability of counselors. While the study does not claim causal relationships or broad generalizability, the findings provide evidence-informed insights that may support culturally responsive practices and structural reforms within counselor education and ED treatment systems (see Burkholder et al., 2020; Ravitch & Carl, 2021).

#### **Implications at the Individual Level**

At the individual level, the findings underscore the importance of culturally responsive therapeutic relationships and clinician reflexivity when working with BIPOC clients experiencing EDs. Participants described that person-centered, culturally attuned care often required counselors to translate standardized ED treatment expectations into interventions that were culturally meaningful and respectful. This included attending to

cultural food practices, language patterns, family roles, stigma, and culturally shaped beliefs about bodies and mental health.

The subtheme of reflexivity and unlearning cultural conditioning suggests that culturally responsive practice begins with ongoing self-examination and humility rather than assumptions of competence based solely on identity. These findings have implications for counseling practice, indicating that clinicians, regardless of racial identity, must intentionally cultivate cultural humility, seek consultation when needed, and avoid treating dominant ED treatment models as universally applicable (Labarta & Bendit, 2024; Shell et al., 2022). For BIPOC clients, culturally responsive engagement at the individual level may reduce shame, increase trust, and strengthen therapeutic alliance factors associated with improved treatment engagement among marginalized populations (Hamilton, 2024; Labarta & Bendit, 2024).

### **Implications at the Family Level**

At the family level, the findings highlight how diagnosis-centered treatment systems may unintentionally undermine family engagement when cultural and contextual realities are minimized. Participants described examples in which treatment plans did not align with families' cultural foods, linguistic needs, or logistical realities, which sometimes increased disengagement or led to family behaviors being interpreted as noncompliance. Culturally responsive family engagement practices such as flexible meal planning that honors cultural foods, improved language access, and respect for culturally influenced stigma dynamics, may strengthen relational trust between families and treatment teams. Although this study did not measure treatment outcomes, the findings

support practical implications consistent with literature suggesting that culturally adapted interventions can improve treatment retention and engagement (Acle et al., 2021; Reyes-Rodriguez et al., 2019). More broadly, participants' emphasis on personhood suggests that treatment teams may benefit from approaching families as partners with cultural expertise rather than as barriers to standardized treatment protocols.

### **Implications at the Organizational Level**

The most direct implications for social change in this study occur at the organization level. Participants described culturally responsive care as frequently treated as an individual responsibility carried by BIPOC counselors rather than as a component of institutional infrastructure. This finding has significant implications for ED organizations because it suggests that cultural responsiveness may be delivered inconsistently and may depend on the presence of BIPOC clinicians who are willing to assume additional professional and emotional labor. Organizational social change therefore involves shifting from individual-based cultural responsibility toward team-wide accountability through training, policy development, supervision structures, and inclusive leadership representation (Shell et al., 2022; Smith et al., 2021). Participants' calls for structural change and representation suggest several organizational practice recommendations within the scope of the data.

First, organizations may implement onboarding and continuing education programs that address culturally responsive ED care, anti-racism, and culturally relevant adaptations to ED treatment protocols. Second, organizations may increase access to culturally responsive supervision and mentorship, particularly for BIPOC clinicians early

in their ED careers, aligning with literature emphasizing the importance of mentorship and deliberate practice (Irvine et al., 2021). Third, organizations may operationalize representation by increasing BIPOC presence in leadership and decision-making roles not as symbolic inclusion, but as sustained participation shaping policy, training, and clinical standards. Finally, organizations may reduce advocacy burden and professional risk by establishing explicit mechanisms for addressing cultural concerns, such as culturally responsive case consultation structures or formal procedures for raising equity-related concerns without fear of retaliation. These changes align with participants' description that advocacy often required escalation and carried emotional and professional consequences.

### **Societal and Policy Implications**

At the societal and policy level, the findings support continued advocacy for reform in how EDs are conceptualized, researched, and treated across diverse communities. As discussed in Chapter 2, ED research and clinical guidelines have historically been shaped by Eurocentric samples and stereotypes, contributing to underdiagnosis and inequitable care among BIPOC populations (Halbeisen et al., 2022; Sonnevile & Lipson, 2018). Participants' descriptions of treatment teams relying on standardized protocols and research-based arguments that lack BIPOC representation reinforce the need for broader systemic change. This includes increasing diversity in ED clinical research, developing culturally relevant diagnostic tools, and supporting workforce development policies that expand diversity within the ED treatment field. Although this study did not test specific policy interventions, it provides lived experience

evidence that may inform professional advocacy within counseling and ED organizations seeking to promote culturally responsive standards.

### **Methodological, Theoretical, and Empirical Implications**

Methodologically, this study contributes to the counseling discipline by applying Giorgi's descriptive phenomenological method to a population and clinical context that has been underrepresented in ED research. The use of transcendental phenomenology supported the ethical centering of participants' voices and offered a structured framework for identifying essential meaning structures that transcend individual accounts while remaining grounded in lived experience (Giorgi, 2009; Peoples, 2021). Theoretically, while the study did not formally adopt the Multicultural and Social Justice Counseling Competencies (MSJCSS) as its primary framework, participants' narratives strongly align with MSJCC principles by emphasizing power, privilege, systemic responsibility, and the need for organizational accountability in culturally responsive practice (Ratts et al., 2016; Singh et al., 2020). Empirically, the findings extend ED workforce and collaboration literature by documenting how training gaps, marginalization, and diagnostic reductionism converge within multidisciplinary treatment settings. These dynamics shape both counselors' professional experiences and the delivery of culturally responsive care to BIPOC clients.

### **Conclusion**

This descriptive transcendental phenomenological study examined the lived experiences of BIPOC counselors providing culturally responsive care to BIPOC clients with EDs while collaborating within multidisciplinary treatment teams. Across

participants' narratives, the essence of the phenomenon reflected a persistent structural tension: culturally responsive ED care was deeply valued and actively pursued by participants, yet it was frequently constrained by inadequate training, diagnosis-centered treatment cultures, and predominantly White professional environments that minimized cultural context while placing disproportionate responsibility on BIPOC clinicians. Participants described entering the ED field through nontraditional pathways and developing competence largely through immersion while simultaneously navigating marginalization, advocacy burden, and expectations to serve as cultural translators within treatment systems that often treated standardized recovery models as universally applicable.

The central take-home message from this study is that culturally responsive ED care cannot depend solely on individual BIPOC counselors. When cultural responsiveness is treated as optional, individualized, or secondary to diagnosis-driven treatment protocols, inequities are reproduced in both clinical practice and professional experience. Centering the voices of BIPOC counselors highlights that meaningful progress requires structural change within counselor education, multidisciplinary team processes, supervision models, and leadership representation. Within the scope of this study, these findings contribute to the counseling discipline by advancing understanding of how culturally responsive ED practice is shaped not only by individual counselor competence but also by systemic conditions that influence whose knowledge is valued, whose voices are heard, and whose humanity is centered in treatment.

## References

- Acle, A., Cook, B. J., Siegfried, N., & Beasley, T. (2021). Cultural considerations in the treatment of eating disorders among racial/ethnic minorities: A systematic review. *Journal of Cross-Cultural Psychology, 52*(5), 468–488.  
<https://doi.org/10.1177/002202212111017664>
- Alexander, L. A. (1998). The prevalence of eating disorders and eating disordered behaviors in sororities. *College Student Journal, 32*, 66–75.  
<https://doi.org/10.7275/7676004>
- Alpers, L. M. (2016). Distrust and patients in intercultural healthcare: A qualitative interview study. *Nursing Ethics, 25*(3), 313–323.  
<https://doi.org/10.1177/0969733016652449>
- Altman, M. R., McLemore, M. R., Oseguera, T., Lyndon, A., & Franck, L. S. (2020). Listening to women: Recommendations from women of color to improve experiences in pregnancy and birth care. *Journal of midwifery & Women's Health, 65*(4), 466-473. <https://doi.org/10.1111/jmwh.13102>
- American Counseling Association. (2014). *2014 ACA code of ethics*.  
<https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf>
- Armour, C. Q., Feicht, B., & Gahagan, J. (2024). Improving adult inpatient eating disorder treatment: Perspectives of a sample of individuals in Canada with lived experience. *Journal of Eating Disorders, 12*(166), 1–13.  
<https://doi.org/10.1186/s40337-024-01121-w>

- ATLAS.ti. (n.d.). *Why ATLAS.ti*. <https://atlasti.com/why-atlas-ti>
- Biang, A., Merlin-Knoblich, C., & Lim, J. H. (2024). An exploration of counselors of color working in the eating disorder field. *Journal of Counseling & Development, 102*(4), 482–494. <https://doi.org/10.1002/jcad.12532>
- Bommen, S., Nicholls, H., & Billings, J. (2023). ‘Helper’ or ‘punisher’? A qualitative study exploring staff experiences of treating severe and complex eating disorder presentations in inpatient settings. *Journal of Eating Disorders, 11*(216), 1–13. <https://doi.org/10.1186/s40337-023-00938-1>
- Bray, M., Heruc, G., Evans, L., & Wright, O. R. L. (2023). The imperative of collaboration: Lived experience perspectives on team approaches in outpatient eating disorder treatment. *International Journal of Eating Disorders, 57*, 116–123. <https://doi.org/10.1002/eat.24084>
- Bray, M., Heruc, G., & Wright, O. R. L. (2024). From silos to synergy: A scoping review of team approaches to outpatient eating disorder treatment. *International Journal of Eating Disorders, 58*, 139–161. <https://doi.org/10.1002/eat.24328>
- Brooks-Ucheaga, M. (2023). A qualitative exploration of Black psychotherapists’ personal experience of racism and the challenges that exist for Black therapists who work with clients in therapy who have also experienced racism. A pilot study using interpretive phenomenological analysis. *The Cognitive Behavior Therapist, 16*(14), 1–13. <https://doi.org/10.1017/S1754470X23000065>
- Burke, N. L., Hazzard, V. M., Karvay, Y. G., Schaefer, L. M., Lipson, S. K., & Rodgers, R. F. (2021). Eating disorder prevalence among multiracial US undergraduate and

graduate students: Is multiracial risk different than the sum of each identity?

*Eating Behaviors*, 41, 101501. <https://doi.org/10.1016/j.eatbeh.2021.101501>

Burke, N. L., Hazzard, V. M., Schaefer, L. M., Simone, M., O’Flynn, J. L., & Rodgers,

R. F. (2023). Socioeconomic status and eating disorder prevalence: At the intersections of gender identity, sexual orientation, and race/ethnicity.

*Psychological Medicine*, 53(9), 4255–4265.

<https://doi.org/10.1017/S0033291722001015>

Burkholder, G. J., Cox, K. A., Crawford, L. M., Hitchcock, J. H. (2020). *Research design and methods: An applied guide for the scholar-practitioner*. Sage.

Chen, C., & Gonzales, L. (2022). Understanding weight stigma in eating disorder

treatment: Development and initial validation of a treatment-based stigma scale.

*Journal of Health Psychology*, 1–18. <https://doi.org/10.1177/13591053221079177>

Cheng, A. W., Nakash, O., Cruz-Gonzalez, M., Fillbrunn, M. K., & Algeria, M. (2023).

The association between patient-provider racial/ethnic concordance, working alliance, and length of treatment in behavioral health settings. *Psychological*

*Services*, 20(1), 145–156. <https://doi.org/10.1037/ser0000582>

Cheng, Z. H., Perko, V. L., Fuller-Marashi, L., Gau, J. M. & Stice, E. (2019). Ethnic

differences in eating disorder prevalence, risk factors, and predictive effects of risk factors among young women. *Eating Behaviors*, 32, 23–30.

<https://doi.org/10.1016/j.eatbeh.2018.11.004>

Choe, E. J. Y., Blake, J., Heuenergarde, M. C., Wells, L. S., and Srisarajivakul, E. N.

(2024). When you are the “other”: A scoping review of the experiences of

- clinicians of color working with White clients. *Journal of Counseling Psychology*, 71(3), 170–178. <https://doi.org/10.1037/cou0000729>
- Crest, P., Vendlinski, S. S., Borges, R., Landsverk, J., Accurso, E. C. (2024). Interdisciplinary perspectives on accessing specialty evidence-based treatment for Medicaid-insured adolescents with eating disorders. *Journal of Eating Disorders*, 12(167), 1–12. <https://doi.org/10.1186/s40337-024-01124-7>
- Creswell, J. W., & Creswell, J. D. (2023). *Research design: Qualitative, quantitative, and mixed methods* (6<sup>th</sup> ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4<sup>th</sup> ed.). Thousand Oaks, CA: Sage.
- Egbert, A. H., Hunt, R. A., Williams, K. L., Burke, N. L., & Jennings-Mathis, K. (2022). Reporting racial and ethnic diversity in eating disorder research over the past 20 years. *International Journal of Eating Disorders*, 55(4), 455–462. <https://doi.org/10.1002/eat.23666>
- Fleming, C., Le Brocque, R., & Healy, K. (2021). How are families included in the treatment of adults affected by eating disorders? A scoping review. *International Journal of Eating Disorders*, 54(3), 244–279. <https://doi.org/10.1002/eat.23441>
- Geller, J., Fernandes, A., Kelly, A. C., Samson, L., & Srikameswaran, S. (2023). Collaborative care in eating disorders treatment: Exploring the role of clinician stress, self-compassion, and compassion for others. *Journal of Eating Disorders*, 11(57), 1–7. <https://doi.org/10.1186/s40337-023-00741-y>
- Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified*

*Husserlian approach*. Pittsburgh, PA: Duquesne University Press.

- Goel, N. J., Jennings-Mathis, K., Egbert, A. H., Petterway, F., Breithaupt, L., Eddy, K. T., Franko, D. L., & Graham, A. K. (2022). Accountability in promoting representation of historically marginalized racial and ethnic populations in the eating disorders field: A call to action. *International Journal of Eating Disorders*, 55, 463–469. <https://doi.org/10.1002/eat.23682>
- Goel, N. J., Thomas, B., Boutte, R. L., Kaur, B., & Mazzeo, S. E. (2022). “What will people say?”: Mental health stigmatization as a barrier to eating disorder treatment-seeking for South Asian American women. *Asian American Journal of Psychology*, 14(1), 96–113. <https://doi.org/10.1037/aap0000271>
- Goode, R. W., Cowell, M. M., Mazzeo, S. E., Cooper-Lewter, C., Forte, A., Olayia, O. I., & Bulik, C. M. (2019). Binge eating and binge-eating disorder in Black women: A systematic review. *International Journal of Eating Disorders*, 53, 491–507. <https://doi.org/10.1002/eat.23217>
- Gordon, A. R., Beccia, A. L., Egan-MPhil, N., & Lipson, S. K. (2023). Intersecting gender identity and racial/ethnic inequities in eating disorder risk factors, symptoms, and diagnosis among U.S. college students: An intersectional multilevel analysis of individual heterogeneity and discriminatory accuracy. *International Journal of Eating Disorders*, 57(1), 146–161. <https://doi.org/10.1002/eat.24089>
- Graham, M. R., Tierney, S., Chisholm, A., & Fox, J. R. E. (2020). The lived experience of working with people with eating disorders: A meta-ethnography. *International*

*Journal of Eating Disorders*, 53(3), 422–441. <https://doi.org/10.1002/eat.23215>

Halbeisen, G., Brandt, G., & Paslakis, G. (2022). A plea for diversity in eating disorder research. *Frontiers in Psychiatry*, 13, 1–8.

<https://doi.org/10.3389/fpsyt.2022.820043>

Hamilton, A. (2024). Black therapists' experiences with their Black clients: A systematic review. *Journal of Marital and Family Therapy*, 50, 150–174.

<https://doi.org/10.1111/jmft.12678>

Harrop, E. N., Hecht, H. K., Harner, V., Call, J., & Holloway, B. T. (2023). “How do I exist in this body...that’s outside of the norm?” Trans and nonbinary experiences of conformity, coping, and connection in atypical anorexia. *International Journal of Environmental Research and Public Health*, 20(1156), 1–17.

<https://doi.org/10.3390/ijerph20021156>

Henricksen, R. C., Yazzie, R., & Huerta, M. (2020). Indigenous counselors' lived experiences of working in mainstream settings: A transcendental phenomenological study. *Journal of Multicultural Counseling and Development*, 48(4), 241–257. <https://doi.org/10.1002/jmcd.12292>

Hipolito-Delgado, C. P., Estrada, D., & Garcia, M. (2021). Countering deficits: A grounded theory of success from graduate students of color. *Journal of Multicultural Counseling and Development*, 49(1), 4–17.

<https://doi.org/10.1002/jmed.12202>

Horn, K., Morgan, R. N., & Franceschi, C. L. (2024). Strategies for creating multidisciplinary community care teams to address barriers to providing family

based treatment of eating disorders. *Pediatric Annals*, 53(1), e22–e27.

<https://doi.org/10.3928/19382359-20231114-01>

Hrovat, A. M., Thompson, L. K., & Thaxton, S. L. (2013). *Preparing counselors-in-training for multidisciplinary collaboration: Lessons learned from a pilot program*. VISTAS Online, Article 82. <https://www.counseling.org/docs/default-source/vistas/preparing-counselors-in-training-for-multidisciplinary-collaboration.pdf>

Husserl, E. (1962). *Ideas: General introduction to pure phenomenology*. (W. Boyce Simpson, Trans.). New York, NY: Collier.

Irvine, T. J., Fullilove, C., Osman, A., Farmanara, L., & Emelianchik-Key, K. (2021). Enhancing clinical competencies in counselor education: The deliberate practice and coaching framework. *Journal of Counselor Preparation and Supervision*, 14(4). <https://digitalcommons.sacredheart.edu/jcps/vol14/iss4/5>

Irvine, T. J., & Labarta, A. C. (2024). Enhancing counselor trainee preparedness for treating eating disorders: Recommendations for counselor educators. *The Professional Counselor*, 14(2), 212–225. <https://doi.org/10.15241/tji.14.2.212>

Jacquart, J., Wardle-Pinkston, S., Ziegler, J., Sbarra, D. A., & O'Connor, M. F. (2024). Improving culturally responsive clinical training: Exploring the acceptability and feasibility of an exposure-based strategy. *Training and Education in Professional Psychology*, 18(1), 87–97. <https://doi.org/10.1037/tep0000462>

Jefferson, A. (2024). “Terminal anorexia”, treatment refusal and decision-making capacity. *Cambridge Quarterly of Healthcare Ethics*, 33(4), 558–569.

<https://doi.org/10.1017/S0963180124000367>

Jennings-Mathis, K., Anaya, C., Rambur, B., Bodell, L. P., Graham, A. K., Forney, K. J., Anam, S., & Wildes, J. E. (2020). Workforce diversity in eating disorders: A multi-methods study. *Western Journal of Nursing Research*, 42(12), 1068–1077.

<https://doi.org/10.1177/0193945920912396>

Jordan, J. V. (2018). *Relational-cultural therapy* (2<sup>nd</sup> ed.). American Psychological Association.

Kanakam, N. (2022). Therapists' experiences of working with ethnic minority females with eating disorders: A qualitative study. *Culture, Medicine and Psychiatry*, 46(2), 414–434. <https://doi.org/10.1007/s11013-021-09721-w>

Kazdin, A. E., Fitzsimmons-Craft, E. E., & Wilfley, D. E. (2017). Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders*, 50(3), 170–189. <https://doi.org/10.1002/eat.22670>

Kerl-McClain, S. B., Dorn-Medeiros, C. M., & McMurray, K. (2022). Addressing anti-fat bias: A crash course for counselors and counselors-in-training. *Journal of Counselor Preparation and Supervision*, 15(4).

<https://digitalcommons.sacredheart.edu/jcps/vol15/iss4/3>

Klein, J. L., & Beeson, E. T. (2022). An exploration of clinical mental health counselors' attitudes toward professional identity and interprofessionalism. *Journal of Mental Health Counseling*, 44(1), 68–81. <https://doi.org/10.17744/mehc.44.1.06>

Labarta, A. C., & Bendit, A. (2024). Culturally responsive and compassionate eating disorder treatment: Serving marginalized communities with a relational-cultural

and self-compassion approach. *Journal of Creativity in Mental Health*, 19(2), 251–261. <https://doi.org/10.1080/15401383.2023.2174629>

Labarta, A. C., Irvine, T., & Peluso, P. R. (2023). Exploring clinician attitudes towards treating eating disorders: Bridging counselor training gaps. *Journal of Counselor Preparation and Supervision*, 17(1).

<https://digitalcommons.sacredheart.edu/jcps/vol17/iss1/2>

Labarta, A. C., Demezier, D., & Vazquez, A. A. (2025). Applying the multicultural and social justice counseling competencies to eating disorder treatment. *Professional Counselor*, 15(1), 17–31. <https://doi.org/10.15241/acl.15.1.17>

Lertora, I. M., Croffie, A., Dorn-Medeiros, C., & Christensen, J. (2020). Using relational cultural theory as a pedagogical approach for counselor education. *Journal of Creativity in Mental Health*, 15(2), 265–276.

<https://doi.org/10.1080/15401383.2019.1687059>

Levitt, D. H. (2006). Eating disorders training and counselor preparation: A survey of graduate programs. *Journal of Humanistic Counseling, Education & Development*, 45(1), 95–107. <https://doi.org/10.1002/j.2161-1939.2006.tb00008.x>

Maia, B. B., de Oliveira-Cardoso, E. A., Pessa, R. P., Pina, M. G. M., & dos Santos, M. A. (2024). Therapeutic bond: Challenges of a multidisciplinary team specialized in eating disorders. *Psicologia: Teoria e Prática*, 26(3).

<https://doi.org/10.5935/1980-6906/ePTPSP16106.en>

Mazzeo, S. E. (1999). Modification of an existing measure of body image preoccupation and its relationship to disordered eating in female college students. *Journal of*

*Counseling Psychology*, 46, 42–50. <https://doi.org/10.1037/0022-0167.46.1.42>

Miu, A., S., & Moore, J. R. (2021). Behind the masks: Experiences of mental health practitioners of color during the COVID-19 pandemic. *Academic Psychiatry*, 45(5), 539–544. <https://doi.org/10.1007/s40596-021-014727-w>

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Munroe, M. (2022). Positive embodiment for wellbeing researchers and practitioners: A narrative review of emerging constructs, measurement tools, implications, and future directions. *International Journal of Wellbeing*, 12(2), 134–162.

<https://doi.org/10.5502/ijw.v12i2.1917>

National Eating Disorders Association (2022a). *Statistics and research on eating disorders*. Retrieved from <https://www.nationaleatingdisorders.org/statistics-research-eating-disorders>

National Eating Disorders Association (NEDA). (2022b). *What are eating disorders?*

Retrieved from <https://www.nationaleatingdisorders.org/what-are-eating-disorders>

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspective on Med Education*, 8(2), 90–97.

<https://doi.org/10.1007/s40037-019-0509-2>

Ng, K.M., Harrichand, J. J. S., Litherland, G., Ewe, E., Kayij-Wint, K. D., Maurya, R., & Schulthes, G. (2023). Interdisciplinary collaboration challenges faced by counselors in places where professional counseling is nascent. *International Journal for the Advancement of Counseling*, 45(1), 155–169.

<https://doi.org/10.1007/s10447-022-09492-y>

- O'Donnell, S. L., & Meloncelli, N. J. L. (2023). Implementing evidence-based eating disorder guidelines at a small metro hospital: Current practice and staff perceptions of caring for eating disorder patients. *Journal of Eating Disorders*, *11*(1), 64. <https://doi.org/10.1186/s40337-023-00787-y>
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4<sup>th</sup> ed.). Thousand Oaks, CA: SAGE.
- Peoples, K. (2021). *How to write a phenomenological dissertation: A step-by-step guide*. Sage.
- Perez, M., Perko, V., Yu, K. Y., Hernandez, J. C., Ohrt, T. K., & Standheim, J. (2021). Identifying central symptoms of eating disorders among ethnic and racial minority women. *Journal of Abnormal Psychology*, *130*(7), 748–760. <https://doi.org/10.1037/abn0000695>
- Puhl, R. M. (2025). Facing challenges for reducing weight stigma in public health policy and practice. *Annual Review of Public Health*, *46*(1), 133–150. <https://doi.org/10.1146/annurev-publhealth-060722-024519>
- Quinn, M. A., & Robinson, S. (2020). College athletes under pressure: Eating disorders among female track and field athletes. *The American Economist*, *65*(2), 232–243. <https://doi.org/10.1177/0569434520938709>
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. <https://doi.org/10.1002/jmcd.12035>

- Ravitch, S. M., & Carl, N. M. (2021). *Qualitative research: Bridging the conceptual, theoretical, and methodological* (2<sup>nd</sup> ed.). Thousand Oaks, CA: SAGE.
- Reyes-Rodriguez, M. L., Davis, K., Patrice, K., & Bulik, C. M. (2013). Exploring barriers and facilitators in eating disorders treatment among Latinas in the United States. *Journal of Latina/o Psychology, 1*(2), 112–131.  
<https://doi.org/10.1037/a0032318>
- Reyes-Rodriguez, M. L., Watson, H. J., Barrio, C., Baucom, D. H., Silva, Y., Luna-Reyes, K. L., & Bulik, C. M. (2019). Family involvement in eating disorder treatment among Latinas. *Eating Disorders, 27*(2), 205–229.  
<https://doi.org/10.1080/10640266.2019.1586219>
- Rubin, H. J., & Rubin, I. S. (2011). *Qualitative interviewing: The art of hearing data*. Sage.
- Scharff, A., Roberson-Miranda, K. L., Sutherland, M. E., and Boswell, J. F. (2024). The predictive efficacy of racial identity attitudes, historically Black college/university attendance, and sources of motivation in Black therapists' career choices. *Professional Psychology: Research and Practice, 55*(3), 209–218.  
<https://doi.org/10.1037/pro0000551>
- Shell, E. M., Hua, J., & Sullivan, P. (2022). Cultural racism and burnout among Black mental health therapists. *Journal of Employment Counseling, 59*, 102–110.  
<https://doi.org/10.1002/joec.12187>
- Shelton, D., & Bridges, C. (2019). Analyzing adoptive parent interviews using the descriptive phenomenological psychology method. In *Sage Research Methods*

*Datasets Part 2*. SAGE Publications, Ltd. <https://doi.org/10.4135/9781526488992>

- Singh, A. A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling & Development, 98*(3), 261–271. <https://doi.org/10.1002/jcad.12321>
- Small, C., & Fuller, M. (2021). *Treating black women with eating disorders: A clinician's guide*. New York, NY: Routledge.
- Smith, L., Proctor, G., & Akondo, D. (2021). Confronting racism in counselling and therapy training – Three experiences of a seminar on racism and whiteness. *Psychotherapy and Politics International, 19*(2), e1579. <https://doi.org/10.1002/ppi.1579>
- Sonneville, K. R., & Lipson, S. K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders, 51*(6), 518–526. <https://doi.org/10.1002/eat.22846>
- Strauch, J., Agnew, A., Meenaghan, E., Miller, K. K., & Haines, M. S. (2023). Recruitment strategies to increase racial and ethnic diversity in anorexia nervosa clinical research. *Journal of Eating Disorders, 11*(1), 118. <https://doi.org/10.1186/s40337-023-00844-6>
- Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: A review of the literature. *Psychiatric Services, 63*(1), 73–78. <https://doi.org/10.1176/appi.ps.201100050>

- Thompson-Burdine, J., Thorne, S., & Sandhu, G. (2021). Interpretive description: A flexible qualitative methodology for medical education research. *Medical Education, 55*(3), 336–343. <https://doi.org/10.1111/medu.14380>
- Uri, R., Wu, Y., Baker, J., & Mum-Chernoff, M. (2021). Eating disorder symptoms in Asian American college students. *Eating Behaviors, 40*, 101458. <https://doi.org/10.1016/j.eatbeh.2020.101458>
- Williams-Ridgway, A., McGowan, R., McNeil, S., & Tuomainen, H. (2025). Eating disorders in minority ethnic populations in Australia, Canada, Aotearora New Zealand and the UK: A scoping review. *Journal of Eating Disorders, 13*(1), 8. <https://doi.org/10.1186/s40337-024-01173-y>
- Willig, C., & Rogers, W. S. (Eds). (2017). *The SAGE handbook of qualitative research in psychology*. Sage.
- Woodruff, K., Clark, L., Joy, E., Summers, S. A., Metos, J. M., Clark, N., & Jordan, K. C. (2020). An interpretive description of women’s experience in coordinated, multidisciplinary treatment for an eating disorder. *Global Qualitative Nursing Research, 7*, 2333393620913271. <https://doi.org/10.1177/2333393620913271>
- Woodruff, K., Joy, E. A., Burns, R. D., Summers, S. A., Metos, J. M., & Jordan, K. C. (2024). A retrospective chart review suggests that coordinated, multidisciplinary treatment for patients with anorexia nervosa improves odds of weight restoration. *Journal of Multidisciplinary Healthcare, 17*, 339–351. <https://doi.org/10.2147/JMDH.S437376>
- Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental

health professionals: A practice-oriented review of recent empirical literature.

*Psychotherapy*, 57(3), 426–436. <https://doi.org/10.1037/pst0000317>

Zanskas, S. A., Brasfield, M., Landry, M., Taylor, L. C., Delavega, E., & Neely-Barnes, S. (2022). Interprofessional training: Preparing graduate counseling and social work students for integrated behavioral healthcare settings. *Journal of Evidence-Based Social Work*, 19(3), 314–330.

<https://doi.org/10.1080/26408066.2022.2049944>

## Appendix A: Interview Guide

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Pseudonym:** \_\_\_\_\_ **Gender Identity:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Location of Interview:** \_\_\_\_\_

**Age Range:** 21-29 30-39 40-49

50-59 60+

**Research Question:** What are the lived experiences of BIPOC counselors' who collaborate with multidisciplinary teams providing culturally responsive care to BIPOC clients diagnosed with eating disorders?

**Sub Question:** How do BIPOC counselors describe their level of preparedness to provide culturally responsive care to BIPOC clients diagnosed with EDs as part of a multidisciplinary treatment team?

### Opening

Welcome, and thank you for taking the time to participate in this research study. The focus of this study is to explore the lived experiences of BIPOC counselors working in the ED treatment field. This interview is expected to take no more than 60 minutes of your time.

As a reminder of the informed consent you previously signed, please know that your participation is completely voluntary. You are free to withdraw from the interview at any point, and you may choose to skip any question that feels to distressing.

To help maintain your confidentiality, no identifying information will be shared and I will provide a pseudonym for the findings of this study. Additionally, this conversation will be audio recorded solely for the purpose of transcription and analysis. Before we begin, may I have your verbal consent to proceed with the audio recording? [*Pause for response*]. Thank you. I'm going to start the recording now. [*Starts recording*]

The interview is now recording, let's begin.

### Interview Questions

1. Can you describe your journey into the ED field as a BIPOC counselor?

2. How would you describe your experiences collaborating with multidisciplinary teams in the treatment of EDs?
3. In what ways do you feel prepared or unprepared to provide culturally responsive care to BIPOC clients with EDs?
4. Have you encountered any challenges or barriers related to your racial or ethnic identity while working in predominantly White ED treatment settings? Can you share specific examples?
5. How do you navigate situations where your cultural insights or recommendations for BIPOC clients may differ from those of your colleagues?
6. Can you describe a time when you felt particularly effective or ineffective in advocating for culturally responsive care within your team? What factors contributed to the outcome?

### **Closing**

This brings us to the conclusion of our interview. Thank you sincerely for sharing your time and experiences with me. The next step will involve reviewing and transcribing the audio recording. I will be the sole person responsible for transcribing and coding the data. Once this process is complete, you will have the opportunity to request a copy of your transcript and connect with me again. I encourage you to review the transcript for accuracy and share any feedback you may have. Please rest assured that your identifying information will remain confidential. The transcript will only be shared with my dissertation committee chair for debriefing purposes.

## Appendix B: Email Invitation

### Subject line:

Interviewing BIPOC counselors in September

### Email message:

There is a new study about the experiences of BIPOC counselors working in the eating disorder field that could help care providers like counselors better understand and help their patients and clients. For this study, you are invited to describe your experiences working in the eating disorder field in collaboration with multidisciplinary teams while providing culturally responsive care to BIPOC clients.

### About the study:

- Participants will be scheduled for one, 60-minute Zoom interview that will be audio-recorded (no video-recording)
- To protect your privacy, the published study will not share any names or details that identify you
- Participants will have the opportunity to engage in member checking and review a summary of the data stemming from their interview

### Volunteers must meet these requirements:

- Identify as a person of color
- Must be 21 years or older
- Holds at least a master's degree in clinical mental health
- Fully licensed independent counselors
- Worked with a multidisciplinary team treating the same client
- Provide direct counseling services to BIPOC clients with EDs

This interview is part of the doctoral study for Melissa Sherfield, a Ph.D. student at Walden University. Interviews will take place during September 2025.

Please email [Melissa.sherfield@waldenu.edu](mailto:Melissa.sherfield@waldenu.edu) to let the researcher know of your interest. You are welcome to forward it to others who might be interested.

## Appendix C: Resources for Participants

Thank you for taking part in this research study. Your well-being is important. If you ever feel overwhelmed, need someone to talk to, or are seeking support, please remember you are not alone. Below are free and confidential resources available to you at any time.

### **Mental Health & Crisis Support (Available 24/7)**

#### **988 Suicide & Crisis Lifeline**

- Call or Text: 988
- Visit: <https://988lifeline.org>
- Free, confidential support for mental health distress, suicidal thoughts, or emotional overwhelm

#### **National Alliance on Mental Illness (NAMI) Helpline**

- Call: 1-800-950-NAMI
- Text: “Helpline” to 62640
- Visit: <https://www.nami.org/help>
- Offers guidance, emotional support, and education about mental health resources

### **Culturally Responsive & Identity-Affirming Services**

#### **Therapy for Black Girls / Therapy for Black Men**

- Visit: <https://www.therapyforblackgirls.com>
- Visit: <https://www.therapyforblackmen.com>
- Directories for connecting with culturally competent therapists

#### **Inclusive Therapists**

- Visit: <https://www.inclusivetherapists.com>
- Directory of therapists specializing in care for BIPOC, LGBTQIA+, neurodivergent, and marginalized communities

#### **The Steve Fund**

- Text: STEVE to 741741
- Visit: <https://www.stevfund.org>
- Crisis support for young people of color, especially students and early-career professionals

#### **Sista Afya Community Mental Wellness**

- Visit: <https://www.sistaafya.com>
- Offers therapy, wellness programs, and community-based mental health support for Black women

**National Queer and Trans Therapists of Color Network (NQTTTCN)**

- Visit: <https://www.nqttcn.com>
- Support network and therapist directory for QTBIPOC individuals

**Eating Disorder-Specific Support****National Eating Disorders Association (NEDA)**

- Call: Helpline – 1-800-931-2237
- Text: “NEDA” to 741741
- Visit: <https://www.nationaleatingdisorders.org>
- Resources, screening tools, and peer support for individuals impacted by eating disorders

**Project HEAL**

- Visit: <https://www.theprojectheal.org>
- Provides pathways to healing for underserved individuals facing eating disorders, including BIPOC clients

**Black and Latinx in Eating Disorders Movement (BALM)**

- Visit: <https://www.balmnation.org>
- Community advocacy and support for Black and Latinx individuals navigating eating disorder recovery and care