

College Counseling Case Studies

Counseling a Biracial Female College Student With an Eating Disorder: A Case Study Applying an Integrative Biopsychosocialcultural Perspective

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This case study describes short-term counseling with a young biracial woman experiencing an eating disorder. A biopsychosocialcultural conceptualization of the problem is described. The counseling approach is informed by feminist and multicultural theory and uses both interpersonal and cognitive behavior therapy.

The abilities to effectively assess and treat dysfunctional eating and weight management behaviors, distressing body dissatisfaction, and diagnosable eating disorders (EDs) are essential skills for campus counseling professionals who work with female student clients (Huebner et al., 2006). Because EDs typically begin in adolescence, college women often bring established eating concerns with them to campus or begin to experience them once they arrive; furthermore, EDs often co-occur with other serious mental health concerns such as mood and anxiety disorders and, in their most serious forms, can lead to self-injury, suicidal situations, or medical complications (Hotelling, 2001). Although certain EDs also are common in men, 90% of individuals with EDs are women (American Psychiatric Association [APA], 2000).

Three major categories of diagnosable EDs currently are recognized (APA, 2000). *Anorexia* is characterized by a refusal to maintain minimally normal body weight and intense fear of becoming fat. *Bulimia* is characterized by out-of-control eating in the form of bingeing episodes along with compensating for overeating via vomiting, severe dieting, laxative use, or overexercise. *Eating Disorder Not Otherwise Specified* (EDNOS) is usually characterized by self-evaluation that is unduly influenced by body considerations, intense fear of gaining weight, disturbance in body image, severe dieting, bingeing, and compensatory behavior that is less than the specific duration, frequency, or severity thresholds for anorexia or bulimia (APA, 2000). By far, EDNOS and diagnostically subclinical eating-related concerns constitute the largest group of eating issues experienced by college women; in fact, although anorexia and bulimia are relatively rare (0.5% to 3.0%), Mulholland and Mintz (2001) found that up to 5% of college women experience EDNOS and 19 to 32% deal with subclinical eating-related problems. These types of problems exist along a continuum. For example, Keel, Heatherton, Dorer, Joiner, and Zalta (2006) reported that although the rate of fully diagnosable bulimia among college students has decreased over the last 20 years, the dangerous practice of purging has not decreased. Furthermore, body dissatisfaction alone can create distress and is a principal risk factor for EDs (Choate, 2005). Correspondingly,

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although treatment of full-syndrome EDs is important, counselors must prepare for the greater numbers of college women experiencing some form of EDNOS (Schwitzer et al., 2008) or other subclinical eating and body image disturbance (Celio et al., 2006; Luce, Crowther, & Pole, 2008).

Understanding ED Behavior

Most experts agree that multiple etiological factors (such as societal pressures, family dysfunction, individual vulnerability, genetics, and trauma) lead to EDs; however, how these factors relate to one another, or combine uniquely in specific individuals, is not yet fully understood (Striegel-Moore & Cachelin, 2001). I believe Connors' s (1996) risk factor model, one of the early risk factor models, is especially helpful for its scope and parsimony (see Figure 1). Connors proposed that known risk factors lead to two central domains, body dissatisfaction and self-regulatory difficulties, and that the severity of these two domains and their potential merging is what leads to *normative discontent* (the term coined by Rodin, Silberstein, & Striegel-Moore, as cited in Connors, 1996, p. 286), to subclinical or full EDs, or to an unrelated problem. When control of one's own body is adopted as a solution to low self-esteem, interpersonal problems, or mood difficulties, an ED seems more likely.

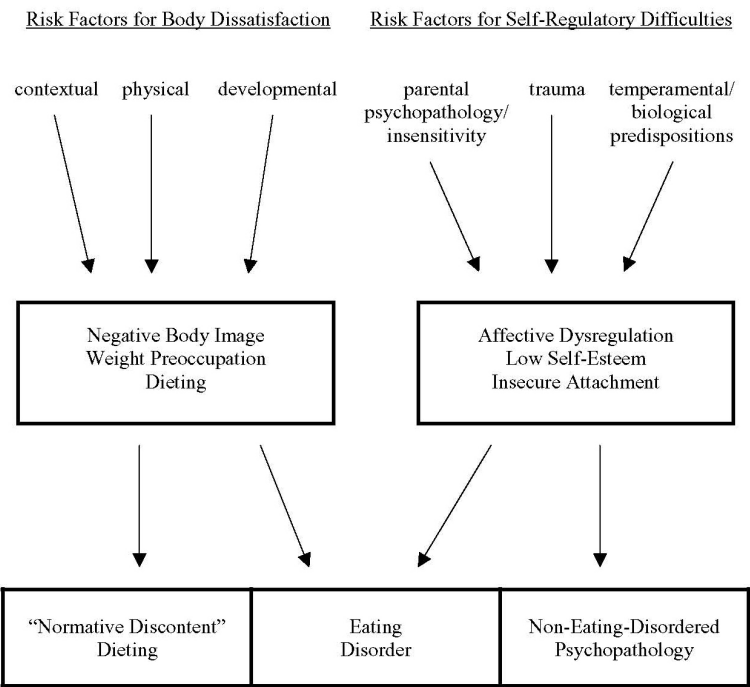


FIGURE 1

A Two-Component Model of Eating Disorders

Note. Adapted from “Developmental Vulnerabilities for Eating Disorders,” by M. E. Connors, 1996, in *The Developmental Psychopathology of Eating Disorders: Implications for Research, Prevention, and Treatment*, p. 299. Copyright 1996 by Lawrence Erlbaum Associates. Adapted with permission.

Gender, Culture, and Multiple Dimensions of Identity

The American Psychological Association, in its comprehensive *Guidelines for Psychological Practice With Girls and Women* (2007), has asserted that women's problems and strengths must be considered not only in the context of the multiple dimensions of identity they inhabit (e.g., culture, class, physical ability, sexual orientation, acculturation) but also in light of their continual subjection to significant levels of discrimination, sexism, and racism. Feminist authors (e.g., Bordo, 1993) have noted that as bulimia emerged among White middle-class girls and women during the 1970s, the cultural context included changing gender roles, an increasingly thin standard of beauty, sexualization of girls, and the relentless targeting of women as consumers. Control of the body and thinness were promoted as viable identities.

EDs are no longer considered exclusive to White women, however (Smolak & Striegel-Moore, 2001), and researchers have indicated that ED symptoms are occurring across diverse groups of college students (Gentile, Raghavan, Rajah, & Gates, 2007; Shaw, Ramirez, Trost, Randall, & Stice, 2004). For example, researchers have suggested that some African American women may have a degree of cultural "protection" against body dissatisfaction, anorexia, and bulimia, but not against binge ED (Wonderlich, Joiner, Keel, Williamson, & Crosby, 2007, p. 175). Likewise, Wonderlich et al. also reported that Latina and Asian American women seem to have a risk level equal to that of European American women. Still, the extant research is sparse, and so far how the complex etiological factors associated with EDs are best understood, assessed, and treated among various ethnic and cultural groups is unclear. In particular, although college and university campus populations are increasingly diverse, very limited research has been conducted concerning bicultural identity, or the effects of discrimination, in relation to EDs (Smolak & Striegel-Moore, 2001).

Treatment Considerations on the College Campus

Because eating-related concerns occur along a continuum (Stice, Killen, Hayward, & Taylor, 1998), counseling strategies are needed that range from early responses for subthreshold problems to more advanced assessment and counseling interventions for clearly present and fully existing EDs (Schwitzer, Rodriguez, Thomas, & Salimi, 2001). It is important for counseling center staff members to determine whether they have the resources to provide adequate care for people with EDs and to refer for a higher level of care when needed (Huebner et al., 2006). Often, short-term counseling is appropriate for people with mild eating and body image problems. Some counseling centers are able to provide more comprehensive care for moderate EDs through team treatment, using medical, psychiatric, and nutritional care in addition to counseling (see Huebner et al., 2006). However, most college centers are not equipped to provide optimal care to severely underweight people, those who cannot keep a meal down or are medically compromised, or those who are highly impulsive or chronically suicidal; these individuals often must be supported through referral to outside resources.

Case Illustration

Introduction of the Counselor

I (the author) am a licensed psychologist with a doctorate degree in counseling psychology. My clinical and research interests are in gender, multiculturalism, and EDs. My therapeutic approach is influenced by feminist and multicultural theory, integrative interpersonal perspectives, and mindfulness approaches to cognitive behavior work. I am a European American woman in my mid-40s. The case example (disguised for purposes of confidentiality) illustrates my work with a young woman with an ED at a university counseling center.

Introduction of the Client

Tanya (a pseudonym) is a biracial woman (African American father and first-generation Japanese American mother), who at the time of counseling was a 21-year-old senior planning to attend medical school. She had no previous experience in counseling but explained that she had been on an antidepressant for approximately 4 months, following a breakdown in which she felt very depressed and confessed to her mother that she had been bingeing off and on since she was 8 years old. The family lived locally and her mother took her to their long-time primary care physician. Although her mood had significantly improved, she had continued bingeing and had begun vomiting. A friend referred her to me.

Tanya was polite but guarded. "I'm not sure I really need counseling," she stated. "I just need to stop the eating. I'm already a big girl and I cannot end up huge like my aunts." Tanya was tall with wide hips, but at an average weight. She reported that she was an only child and that her parents had divorced when she was 5 years old. She had lived with her mother in a predominantly White, upper middle-class area but spent a good deal of time with her paternal grandmother and aunts. She said her father had done well in business and that her mother "just works her life away." Tanya thought she may have been depressed off and on as a teenager, but nothing as bad as the breakdown, which was precipitated by a falling-out with a group of friends from high school. She was academically successful and highly driven. She also sang with a women's a capella group on campus.

Diagnostic Impressions and Assessment Considerations

Tanya reported a long history of overeating and sneaking food, but she had been experiencing more severe binges about once a week for 2 years. She had been vomiting for 2 months. She denied any history of abuse, trauma, substance abuse, or suicidality. Trying to understand what role gender socialization and racial identity played in Tanya's experience was important; this was an ongoing assessment process and part of the counseling itself. Although Tanya identified most strongly as African American, she revealed over time that she was very much in the process of sorting out her feelings regarding her biracial heritage. Issues of race were intertwined with gender and class as well. As we proceeded, I would ask Tanya questions like, "What messages have you received about being a woman, a Black woman, a biracial woman?" "What women do you admire

and what do you like about them?” and “How do your ideas about being a woman of Asian and African descent impact your feelings about your body?”

I formulated my tentative diagnosis, using the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; APA, 2000):

- Axis I: Eating Disorder Not Otherwise Specified; Major Depressive Disorder, in Partial Remission (Provisional)
- Axis II: No diagnosis
- Axis III: No diagnosis
- Axis IV: peer conflict, racial identity struggles, academic pressure
- Axis V: GAF: 60

Although the GAF score represents global functioning and in many ways Tanya was functioning very well (e.g., strong academically, improved mood), the relatively low number reflects the symptom severity. When level of functioning differs from symptom severity, the *DSM-IV-TR* is clear that whichever one is lower is to be used (APA, 2000).

I worked with a multidisciplinary ED treatment team; however, we offered only short-term treatment (15 weeks). A critical part of assessment was determining whether the treatment team could adequately meet the client's needs. Tanya was ambivalent toward counseling but motivated to stop the ED behaviors; her mood was relatively stable, she was medically stable, and she had significant strengths on which to build. Furthermore, although her symptoms seemed to me to be serious, the vomiting was more recent, and capitalizing on her level of motivation seemed very important.

Case Conceptualization

I attempted to understand Tanya's presenting concerns from as broad a biopsychosociocultural perspective as possible, and use Connors's (1996) model (see Figure 1) to illustrate. Tanya struggled with negative body image (the left side of the model) and low self-esteem (the right side). I will add that in my view, and from a feminist perspective, contextual (sociocultural) factors influence both sides.

Tanya reported a number of experiences that were risk factors for body dissatisfaction. She had been teased by peers at a young age for being fat, bookish, and physically awkward, and the slights often had racial overtones. Food was a source of comfort. As Tanya grew into adolescence, she made friends across racial groups, but tensions continued. She began dieting regularly. Regarding gender role, she received mixed messages, with her African American aunts encouraging her to be assertive and her mother insisting that she show more decorum. Both sides of her family supported her desire to be a doctor. No one knew the extent of her bingeing.

Tanya's social status increased when she started attending college. Her intelligence and drive were more appreciated and people increasingly commented on her beauty. However, she found herself at odds with African American young women, the group with whom she most strongly related. In addition, she identified as straight but was uncomfortable with male attention and had almost no sexual experience. Throughout her life, Tanya drew on a variety of coping mechanisms: humor, studying, fantasizing about being thin, and eating.

Tanya also reported a number of experiences that were risk factors for self-regulatory difficulties and which may have contributed to her low self-esteem and mood difficulties. Mood and anxiety problems in the parents and high weight in other relatives suggested the possibility of biological or temperamental predispositions toward EDs. The other contributors seemed to be relational and influenced by the social context, which affected her ability to regulate her mood.

Tanya's relationship with her parents seemed good in many respects and likely helped provide her with a degree of resilience and the ability to resist a full-syndrome ED; however, she was of the opinion that she had been left to fend for herself a good deal. She perceived her mother as passive, overly anxious, and in need of protection. She had not partnered after her divorce and Tanya worried about her. Few things were overtly discussed: "She's never known what my world is like. . . . She has no idea." This referred in part to her mother's inability to help her navigate various developmental and racial tensions while growing up. Tanya did not seem to know much regarding her mother's cultural background and had little contact with her mother's family.

Tanya's relationship with her father was one of alternating affection and frustration, because his attention had been intermittent at best. He had partnered with a number of other women and struggled with depressed moods. He supported her dieting, telling her she could be "stunning" and "exotic" if she lost weight. She was closest emotionally to her father's sisters and mother, and these relationships were clearly important to her development and resilience. However, she judged her paternal grandmother and aunts harshly for being obese, and she felt she could not talk to them about her weight or her associated hopes and dreams.

Although Tanya denied any overt experiences of trauma, my sense was that a lifetime of racial microaggressions (see Sue, Bucci, Lin, Nadal, & Torino, 2007), particularly from peers, had influenced her ability to trust. She ended up feeling she did not fit in well anywhere: not with either side of her family, not with any racial group, and not with girls or boys. Although she coped well using humor, and people were attracted to her, she got hurt and angered quickly. She experienced frequent ruptures with friends. Being an only child was hard on her, and family had not been able to help her successfully navigate peer relationships and bicultural issues or to manage emotions.

Costin (1999) stated that EDs are essentially adaptive functions, if misguided ones, that attempt to "cope, communicate, defend against, or even solve other problems" (p. 62). My working hypothesis with Tanya was that the adaptive function of the ED helped her soothe interpersonal disconnection and identity concerns. Objectified as exotic by her father, considered somewhat alien by her mother, and both ridiculed and envied by her peers, her development of a positive female and biracial identity had been hampered. Food was a reliable soother but ultimately became an enemy; the "solution" Tanya developed was to become professionally successful and thin.

Feminist-informed therapy generally views clients' symptoms as attempts to cope with difficult situations, and it strives to honor clients' strengths (Enns, 2004). The very qualities that made Tanya vulnerable to a false sense of self were also the ones that could lead the way to a stronger self: a deep desire for connection, sensitivity, conviction, and competitiveness and the need to achieve.

Multidisciplinary EDs Team Treatment

Advantageously, I was able to work with a team consisting of medical doctors, dietitians, and psychiatrists, as well as other counseling professionals. We met once a month as a group and collaborated individually as well. Clients were informed of the team and gave their consent. I generally discussed new clients with team members and sought consultation; at that point, we would determine whether counseling alone or other care was optimal, and, of course, things often changed as treatment progressed. Tanya was already bonded with her family physician, and because he was local and willing to collaborate with me, I worked with him via telephone regarding her medical stability and antidepressant medicine. Tanya also met with one of our dietitians for a consultation, but ongoing meetings were not needed because she readily grasped the concepts and worked well with me on implementing them.

Individual Counseling: Course of Treatment

A few central principles helped guide me in my work with Tanya. Linehan's notion (see Robins, Schmidt, & Linehan, 2004) of complete acceptance of the client and the simultaneous understanding that things must change was pivotal to (a) managing my own desires for her wellness and (b) helping her manage her goals of eliminating bingeing and purging (i.e., toleration of setbacks, acceptance of her own ambivalence). Establishing normal eating behavior was crucial, but a key was to help her shift from a self-critical approach to wellness to one that was grounded in self-acceptance. Also pertinent were two themes derived from feminist research on how clients began to heal: they recognized that the ED was not a viable solution to their problems, and they began to move toward people rather than away from them (Peters & Fallon, 1994).

My first goal was to connect with Tanya. I worked to provide her with confidence in my abilities, but attempted to do so in a way that was as egalitarian and collaborative as possible. I sought to reduce shame around the ED and signal that I was receptive to talking about race and gender. I invited Tanya to tell me all she knew about EDs, which was a way to assess what information she needed. After some negotiation, we agreed that I would collaborate with her family doctor and that she would consult with our dietitian. She declined group therapy.

Beginning phase. I asked Tanya to read Fairburn's (1995) *Overcoming Binge Eating* because it provides both a strong rationale for *normal eating* (three meals and two snacks a day) and numerous behavioral strategies for clients to try. We discussed the starve-binge-purge cycle at length and how maintaining the meal plan can begin to bring a sense of normalcy to the body. I asked if she could delay any attempts to lose weight for now and allow her body to adjust to normal eating. Although this was difficult for her, she committed to the idea.

Tanya was stoic; she rarely cried and she often related painful things in a flip-pant manner. She could not identify what was happening emotionally when she began to binge. At first, I simply listened and validated her feelings and experiences. I learned to offer a kind of matter-of-fact empathy: not too sympathetic, but definitely attentive. Anything more was rejected.

Tanya began to talk in some detail concerning the struggles she was having with the women in her choral group. I listened for content (criticism directed at

her), process (allusions to race, related by her with the usual humor and irony), and emotional themes (anger, hurt, withdrawal). She described the women as being intensely competitive about who got to sing solos, who was dating whom, and how they looked. It was a racially mixed group, and Tanya found herself in all-too-familiar territory, caught between cliques, trying to be friends with everyone, and feeling excluded and angry. Currently, she was being challenged by two African American friends in the group for being “stuck up.” I engaged in the back-and-forth of the story for some time, clarifying her feelings and attempting to provide an experience in which she did not feel judged by me. Finally though, I asked her how she felt about discussing these issues with a therapist who was White, twice her age, and rather small in size. There was a long pause. “Yeah, when I first saw you, I didn’t think this was going to work,” she said, eyeing me cautiously. But she relaxed when I did not react defensively, and our sessions took on a deeper tone after that. Tanya expressed that on the one hand, she felt as if she could move among many different groups of people and be comfortable, but on the other hand, she was not sure if she really belonged anywhere.

Working phase. One of the behavioral strategies on which we worked was delaying binges. This helped build her confidence, because the goals were attainable (e.g., recognize the desire to binge and delay it for 30 minutes), and the process increased her ability to recognize thoughts and feelings. Tanya began to devise her own strategies for delaying and reducing binges, and she adapted recommendations from Fairburn’s (1995) text, a clear indication of her resourcefulness.

A central theme occurred around hair. “Do you know about Black women and hair?” she asked me in her usual forthright manner. Her long hair and medium-toned skin had been sources of both ridicule and envy since grade school (and within the extended family as well), and continued now in the singing group. It was not an easy topic, particularly because Tanya had begun to slow down in sessions and analyze in more detail what she was feeling. It ran so deep, from an early awareness that her mother did not know what to do with her hair, through the snide but envious comments by her cousins and African American girlfriends, to her own secret enjoyment of it and the sense of power it gave her. Men liked it. The focus on hair created opportunities for us to talk about how racism and sexism can be enacted in small ways that can accumulate over time and take a toll. She was surprised that I knew something about Black women’s hair care, which gave me more credibility in her eyes. It also provided a way to talk about the confusing experience of feeling both powerless and powerful at the same time.

We explored cognitive distortions and beliefs around being thin. Although helpful to look at dichotomous thinking, I more typically worked in a mindfulness-oriented way, asking her to observe herself, her thoughts, and her interpersonal process, but not judge them. Recognizing her process and having compassion for it, I suggested, could lead to more creative ways of being and thus to the expansion of her repertoire. I believe this conveyed a fundamental respect for her experience but still provided an avenue for change. It also led to some expansion of emotional expression with me.

“Why do I have these hips if I’m part Asian?” she asked humorously. When I remained silent, she teared up. Although Tanya was indeed proud of her heritage, she had also absorbed negative stereotypes concerning both groups. I engaged

tentatively concerning this topic at first; as before, things shifted when I disclosed some of my own process and dilemma. I told her that we all are exposed to a variety of negative stereotypes regarding women, but that she may have had more than the usual share negotiating her biracial status in White-dominant environments. My dilemma was that I wanted to ask her more about it but did not want to be invasive. I also acknowledged the obvious fact that my experience was different from hers.

Tanya engaged further. Her realization that she liked the way her biracial heritage had contributed to what others viewed as beautiful and interesting in her but that she also viewed her Asian heritage (and her mother to a degree) through a rather demeaning lens was painful to her. Whereas she identified positively with her African American background, she did not always feel entirely like an insider. She also viewed her aunts' acceptance of larger body types as culturally "ignorant" and felt justified in this belief by her more sophisticated understanding of medicine and health. I gently challenged that although heavier weights and diabetes in the African American community were indeed significant, it did not follow that appreciation of different body types was ignorant. Tanya engaged actively around the topic and was also willing to observe her thought processes and question her beliefs.

One interpersonal cycle she repeatedly experienced was initially trying hard to please someone, then getting angry and withdrawing if her efforts were not rewarded in the way she expected. Often, other people seemingly had no idea they had hurt her. Some of this resulted from others' insensitivity, no doubt, but Tanya began to recognize that she was so used to being slighted that she could not distinguish between deliberate attacks, inadvertent thoughtlessness, and things having nothing to do with her. She also recognized that people liked her when she showed a little vulnerability, but she usually felt it was too risky. However, she began to experiment with choosing more deliberately with whom to be open, and this she found exciting and empowering.

Ending phase. Tanya had gradually reduced her bingeing and stopped purging. We began to prepare for termination. My hope was that if we could focus on the gains she had made, she would be able to continue the healing process on her own or with another therapist. Approximately 4 weeks before we ended, she had a resurgence of purging, which gave us the opportunity to review our process and talk about continued care and relapse prevention.

We revisited some of the questions I had put to her over time: "What would you lose if you accepted your body?" "How does the image you have of the 'ideal professional Black woman' relate to your symptoms?" Her reflections were becoming increasingly insightful. She realized that she had been operating on the assumption that if she let herself feel good about her body, others would condemn her for acting superior. Others did accuse her of this, but Tanya had begun to realize that authentically feeling good about herself was not the cause of her interpersonal struggles. She also decided that the ideal image she held was counterproductive (although she was not quite ready to relinquish it).

I felt cautiously optimistic as we said goodbye. I expressed my confidence in her, in the ways she had grown, in her commitment to her health and well-being, and in the many strengths she had brought to bear and would continue to use. I also expressed my concern that the stressful world of medical school could hinder her ability to build on the gains she had made, and we discussed continued support

at length. The best part, she said, was knowing that she had the skills to stop the ED behaviors, and that therapy could be a positive experience.

Conclusion

The difficulties experienced by the client portrayed in this case example are representative of the ED concerns commonly presented at college counseling centers, and the case reflects the benefits and limitations of the short-term work permitted by the institutional contextual constraints typical of college and university counseling centers. As is often the case, Tanya's degree of recovery was not entirely clear at the time of termination, and the client and I felt that much was left unexplored; nevertheless, I believe that our work together provided Tanya with a good foundation for continued growth. Furthermore, I had observable and measurable outcomes indicating the successes of our course of counseling: cessation of purging (including recovering well from a relapse), reduction of bingeing from once a week to approximately once every 3 weeks, reduction in the severity of the bingeing (amount of food and length of time to stop), increased ability to express and tolerate emotional states, increased appreciation of her racial background (exhibited in part by an increase of interest in her mother's culture), and increased recognition of interpersonal dynamics along with beginning attempts to alter her own patterns. In addition to multidimensional treatment (e.g., medical, psychiatric, nutritional), the counseling experience included exploring the influence of stereotypes and discrimination, viewing symptoms as coping strategies, working with strengths, increasing self-acceptance and tolerance for emotion, and improving interpersonal skills. Behavioral strategies helped facilitate change as well, and a process toward increased cognitive flexibility was begun.

It should be carefully noted that more empirical support can be found in the literature for using standard cognitive behavior therapy or interpersonal therapy for EDs than for using integrative approaches such as the one I have demonstrated here. However, the research has primarily been limited to European American women. Although certain cultural protection against EDs may be available to some African American women, evidence also exists that many women of color with EDs do not present for treatment or do not remain in it if they do present (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001). Although counselors should, of course, avoid overly narrow assumptions concerning a client's eating behaviors or body image solely on the basis of race or culture, my clinical experience has been that a counseling perspective that incorporates attention to cultural factors with established treatment approaches may be most helpful for engaging and assisting diverse student populations with gender-related eating concerns.

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