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Therapists' Experiences Treating Asian American Women With Eating Disorders

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How do psychologists treat eating disorders (EDs) and subclinical issues in Asian American women in a culturally competent manner? Disordered eating and body dissatisfaction are so common in women that most therapists work with the issues to some degree, and it is increasingly likely they will see women of color. Asian American women are at significant risk and yet little treatment literature exists. Twelve therapists with experience in ED treatment were interviewed about their work with Asian American women. Grounded theory and consensual qualitative analysis methods were used to analyze the data, resulting in two central domains of *conceptualization within the cultural context* and *treatment approach*. Therapists reported that their clients were mostly first- and second-generation Americans who experienced *acculturation stress* and *cultural conflict*, particularly with elders. Other results suggested therapists perceived a strong connection between clients' desires to be thin and successful, and clients' efforts to conform to traditional Asian cultural values and fit in with U.S. mainstream culture. Therapists emphasized the cultural contextualization of family dynamics, developmental processes (e.g., individuation), and intergenerational conflicts. They viewed EDs as providing clients with culturally congruent coping strategies to affectively disconnect and to express distress. Treatment themes centered on psychoeducation and the importance of including parents in the treatment of their adult daughters. Helping clients navigate autonomy within the family and cultural context, and challenging clients and parents on the cultural (both Asian and mainstream U.S.) pressures regarding achievement and beauty were particularly important. Implications for therapy are discussed.

Keywords: eating disorders, Asian American women, treatment, acculturation stress, conceptualization

Experts (e.g., Root, 2001; Stein et al., 2001) have called emphatically for more research regarding etiology and treatment of disordered eating and body dissatisfaction in ethnic minority women. Although full syndrome eating disorders (EDs) are relatively rare and prevalence across cultures is still not well understood, Asian American women are clearly at risk (Wildes, Emery, & Simons, 2001). Methodological problems hamper much of the research, but a well-designed study by Shaw, Ramirez, Trost,

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Randall, and Stice (2004) determined that U.S. ethnic minority groups "may have reached parity in terms of eating disturbances" (p. 16) with European American groups, and a meta-analysis by Wildes et al. (2001) concluded that Asians and Asian Americans had equal or greater rates of disturbed eating as did Whites. Further, although some Asian Americans may be more concerned with the shape of body parts than with weight (Mintz & Kashubeck, 1999), a substantive review by Grabe and Hyde (2006) found comparable rates of body dissatisfaction between Asians and European Americans. The suffering related to EDs can include depression, anxiety, suicide, and medical complications (Kashubeck-West & Mintz, 2001), and due to evidence that women of color seek treatment for EDs at lower rates than do European American women (Franko, Becker, Thomas, & Herzog, 2007), concern for Asian American women is great.

In spite of an enormous ED treatment literature, ethnic minorities are rarely included in treatment trials, and case studies with Asian American women are rare. With the exception of one study (Chui, Safer, Bryson, Agras, & Wilson, 2007), therapists will find little empirical research on treatment with this population. Stein et al. (2001) pointed out that research on ED treatment is inherently difficult (e.g., relatively low prevalence and high drop-out), and even more difficult with ethnic minority women due to low help-seeking. Nevertheless, conceptualization and treatment planning within the contexts of culture, acculturation, and gender role socializations are a foundation of culturally competent treatment (American Psychological Association, 2007). Therefore, in the present study we sought the knowledge of therapists who have been working with Asian American women experiencing eating and body image problems. Although it is problematic to use the term *Asian Americans* to refer to such a diverse group, we do so in an effort to gain knowledge about women who share common cultural influences and have been too rarely studied. This study provides a descriptive and preliminary view into this group, and into therapists' conceptualizations and treatment strategies within a specific cultural context.

Method

Researchers

We (the two primary researchers) are women psychologists (European American and Taiwanese American) with backgrounds in multicultural research and experience treating diverse clients with EDs. Three Masters-level counseling students (all women; 1 Vietnamese American and 2 European American) contributed to the data analysis. Two other women psychologists (1 Mexican American and 1 Japanese American) served as outside auditors. All four psychologists have degrees in counseling psychology and have been trained in qualitative methods.

Participants

Twelve therapists (11 females and 1 male; 10 psychologists and two marriage and family therapists) on the West coast of the U.S. were interviewed. They identified as Asian American ($n = 7$), European American ($n = 4$), and Latina ($n = 1$). Their ages ranged from 33 to 56 ($M = 42.30$; $SD = 6.73$) and their years of practice ranged from 5 to 20 ($M = 10.92$; $SD = 4.19$). They worked in independent practice, university settings, and ED clinics, and identified as having ED expertise. One therapist had experience with four in-depth cases involving Asian American clients; five had worked with 5–10; two had worked with 11–20; and four had worked with over 20.

Procedure

We recruited participants through purposive sampling (Creswell, 2008), seeking those who identified ED treatment as an area of specialty and had worked with Asian American women. When therapists had seen a small number of Asian Americans, we only included them if that work had been in-depth. More specifically, we used theoretical sampling (Corbin & Strauss, 2008), choosing people from different settings and backgrounds that would help illuminate the concepts that were emerging from the data. We stopped interviewing at saturation, when the additional data were no longer revealing new information (Corbin & Strauss, 2008).

As is common in qualitative approaches, we developed a semi-structured interview protocol, with open-ended questions. We asked participants to discuss their approach to ED treatment, and their work with Asian American women with EDs (including a case or two, and how they integrate cultural concepts in their work). We separately conducted and audiotaped 1-hr interviews by phone or in person. Three trained graduate students transcribed the tapes.

Approach to the Data

We combined aspects of two qualitative analytic strategies: grounded theory (GT; Corbin & Strauss, 2008) and consensual qualitative research (CQR; Hill et al., 2005). Although GT typically involves theory-building, it can also be used solely as a means of systematically deriving themes in order to describe phenomena (Corbin & Strauss, 2008), which was our purpose, given the preliminary nature of the study. This approach allows the raw data to guide the emergence of themes, rather than researchers beginning with preconceived themes. We adopted techniques from CQR (group consensus and an auditing process) as methods of triangulation. Two auditors independently examined both the raw data and the final coding structure and provided feedback. Finally, we utilized *member checking* and asked the participants to provide input on the coding structure and narrative description of results.

Coding process. Using the computer program NVivo (version 8; QSR International) to help track and sort the data, we (the two primary researchers) independently coded the first three interviews to form an early thematic structure. Each of us conducted simultaneous *open coding* (sentences and paragraphs were broken down and labeled as codes) and *axial coding* (concepts were related to each other) and developed higher-level *themes* that could encompass the lower-level concepts (Corbin & Strauss, 2008), and then we discussed our impressions and came to consensus. Consistent with GT, we allowed for flexibility in the interviews in order to explore territory we had not anticipated. We went back to the coded data after every few interviews and compared our new findings with them, and altered the thematic structure accordingly. Three graduate students worked with us to examine the categories, question our biases and perceptions, and reach consensus on the coding. For example, based on our personal and clinical experi-

ence, we perceived Asian American women as less likely to utilize drugs and alcohol as coping mechanisms to the degree that other groups did, and had begun to think of EDs as a dominant form of culturally congruent coping. The students disagreed and helped us look again at what the therapists had actually said. The resulting coding structure and raw data were then reviewed by the auditors, and revised again by the primary researchers.

Results

Two higher-order themes are explored here: therapists' conceptualizations and approaches to treatment. We also describe the most salient subthemes. The complete list and frequencies are presented in Table 1. We have provided pseudonyms for the therapists.

Table 1
Categories and Frequencies of Therapists' Conceptualizations and Treatment Approaches

Category	Frequency	
Conceptualization of ED within the Cultural Context		
Achieving at all costs	General	
Academic and career	Typical	
Physical appearance	Typical	
Plastic surgery		Variant
Culture-Specific Factors	General	
Traditional Asian cultural values	General	
Conforming to the norm	Typical	
Thin and petite as the expectation	Typical	
Family recognition through achievement	Typical	
Filial piety		Variant
Gender role expectations	Typical	
Values on control and restraint		Variant
Acculturation Stress	Typical	
Idealization of Western beauty standards	Typical	
Role of stereotypes and racism		Variant
Role of Family	General	
Communication style	Typical	
Intergenerational acculturation conflict		Variant
Hierarchical		Variant
Comparison and criticism		Variant
Love and affection		Variant
Family dynamics	General	
Individuation and autonomy		Variant
Father–daughter dynamics		Variant
Mother–daughter dynamics	Typical	
Messages about food and eating	Typical	
Culturally normative coping strategies	Typical	
Affective disconnection	Typical	
Expression of distress	Typical	
Treatment Approach		
Therapeutic Emphases	General	
Crisis intervention		Variant
Psychoeducation	Typical	
Reframing EDs as coping		Variant
Connecting affect and behavior		Variant
Dealing with perfectionism and self-criticism		Variant
Challenging cultural norms		Variant
Self-care and nurturing		Variant
Cultural adaptations to mainstream therapy	General	
Expanding therapists' value systems		Variant
Establishing trust and rapport		Variant
Dealing with shame		Variant
Attending to cultural experiences		Variant
Adjustments to standard methods		Variant
Accommodating family styles	Typical	
Working with family dynamics	Typical	
Working with parental resistance		Variant
Educating parents	Typical	
Facilitating communication	Typical	
Facilitating autonomy within the cultural context		Variant

Note. $N = 12$. General = a category endorsed by 11 or 12 therapists; Typical = a category endorsed by 6–10 therapists; Variant = a category endorsed by 2–5 therapists; Categories endorsed by only one therapist were dropped.

The therapists discussed 18 women clients in some detail and referenced a total of 27 (9 Korean American; 4 Chinese American; 2 Biracial; 1 Japanese American, 1 Philipino; 1 Indian American; 1 former USSR; 8 of unidentified Asian descent). The majority were first- or second-generation and between 18 and 25 years old. Clients ran the gamut of eating disturbances. The therapists saw clients who did not know they had an ED, who presented with depression or anxiety initially, whose primary distress was the shape of their faces, and whose families knew little about EDs. No dominant diagnostic picture emerged. However, seven therapists perceived trends within their own practices: Sonya, Jen, and Amy stated that subclinical and atypical EDs were more common; Mae, Jen, and Pam stated that EDs were rarely the presenting issue; Mae and Jen said their clients tended to be restrictive; and Pam, Ila, and Amy found body dysmorphia to be salient. Lucy and Jen did not find DSM diagnoses particularly helpful to their work, and many described clients with a mix of subclinical features. When therapists did refer to diagnoses, five clients were identified with anorexia (AN), six with bulimia (BN), and one with binge eating. An additional seven had predominantly restrictive symptoms; one had bulimic symptoms.

Conceptualization of EDs Within the Cultural Context

All the therapists acknowledged the complexity of factors leading to EDs, and that they had seen similarities across cultures; however, they also noted more culturally specific factors.

Achieving at all costs. All the therapists expressed that their clients were often under extraordinary pressure to achieve in academics, career, and appearance; furthermore, some felt that sacrifice was required of their clients, whether it was to delay social activities (e.g., until school was finished) or use any means to achieve an optimal appearance (e.g., plastic surgery).

Culture-specific factors. A number of therapists highlighted the importance of *conforming to the norm*, and asserted that thinness in women was in itself a part of conforming. Nine therapists contended that Asian American women are held to higher standards of thinness (e.g., more "exacting and narrow," stated Lucy) than are European American women. The idea that the *family as a collective unit* gains pride through a member's achievement and appearance struck nine of the therapists as particularly significant: clients often struggled with trying to be pleasing to others (especially parents), and meeting expectations to be selfless, accomplished, and attract the proper mate. Filial piety (respect for elders) required that young women, for example, not reject food offered to them by elders, but gender role norms also required they not gain weight. Clients experienced acculturative stress as they struggled to reconcile traditional Asian (e.g., emotional restraint and family privacy) and mainstream U.S. values.

Half of the therapists reported that with this acculturative stress came an *idealization of Western beauty norms* by clients and parents. Mae stated that sometimes one could "be the only Asian American around and so already you sort of are standing out, you look different, you don't feel beautiful . . . ." Ila was struck by the "sense of abhorrence" her clients had about their faces and bodies and how even their parents encouraged an "Americanized" look, sometimes with plastic surgery. The parents' desire that their children fit in was palpable, even as they restricted them from other mainstream activities (such as dating). Lucy stated, ". . . what I find is that people who are interested in acculturating, who want to be part of the mainstream society—who idealize, let's say, the Western cultural values—are more likely to have eating issues."

Role of family. All the therapists described family dynamics relevant to their clients' EDs. Four saw that independence and autonomy loomed large. Lucy stated: ". . . the parent sense of self being linked to the children's achievement, I see that more pronounced in Asian clients. So that there's a less degree of individuation; the parents are often more intrusive and meddlesome in the children's affairs." Three spoke about the conflict that arose when parents utilized a traditionally Asian authoritarian parenting style with their more U.S. mainstream-acculturated daughters. Mae stated: ". . . because of the hierarchical role you know, the person of the higher status doesn't have to sort of beat around the bush and say things nicely . . . ," referring to the blunt style of elders. "You sure got fat," was an example she and Ann gave. Ann explained that the lack of social niceties, from the perspective of parents, can be a sign of love (familiarity). Parents also tried to motivate their children through criticism and comparison to others, which distressed clients who had observed more affectionate styles in their mainstream-culture peers.

Culturally normative coping strategies. Ten of the therapists reported that EDs were a way their clients coped with the stresses of biculturalism, achieving, individuation, or, in rare cases, abuse. Two general strategies were evident: the EDs were a way to disconnect emotionally and express distress covertly. A number referred to a "lack of voice" in their clients, sometimes due to not having an emotional language or not feeling permitted to express personal desires or disappointments. Disconnecting from their own emotions seemed to allow clients to conform to family demands while reducing the distress of having personal desires that may conflict with those demands (e.g., wanting a different college major or a romantic relationship).

Treatment Approach

Therapeutic emphases. A number of common strategies emerged in the therapists' treatment approaches. Most provided psychoeducation, many framed EDs as coping strategies, and nearly half attended to perfectionism and affect: This was characteristic of their work with clients across cultures. However, all the therapists spoke about the ways in which they adapted their therapeutic style at times to better suit the culture of their Asian American clients.

Cultural adaptations to mainstream therapy. Nearly half of the therapists discussed the importance of normalizing therapy, citing drop-out rates and shame. Four said they attended to their clients' experiences as Asian American women directly, addressing their beliefs about their facial features and body types, as well as their cultural identities. Challenging Asian cultural norms at times was important. "People often come to therapy with the idea that if they practice something that is culturally normative then it is, it must be okay," said Lucy, adding that she discusses with clients how all cultures have healthy and unhealthy norms. Some therapists made adjustments that were uncharacteristic of how they worked otherwise, particularly around family (e.g., Ila agreed to see a client's sibling due to the trust that had so carefully been built

with the family; Jen worked with a client whose mother sat in on sessions only to observe and learn).

Working with family dynamics. Four of the therapists described cases in which parents were instrumental to outcome, for good and bad. They expressed frustration with parents' responses of "yes, yes, yes," when there was a crisis, only to not follow through later. Pam and Lee described cases in which the parents refused to acknowledge the problem: the adult client never returned for treatment and the minor client finally received medical attention when the therapist threatened to call child protective services. Lucy discussed two similar cases in which the parents acknowledged the problem but circumvented the therapeutic process by employing cultural pressure: "You can't do this to us," was the message to one daughter, and the intensity of filial piety and family responsibility appeared to induce a positive change.

Half of the therapists stressed the importance of educating parents about EDs. Many said that first- and second-generation Asian American families did not seem to be as well-informed as their other clients. Lucy (herself Asian American) explained that education was also about helping parents understand notions of individuation, privacy, and boundaries. She and two other Asian American therapists spoke the most forcefully about the need to help clients individuate, within cultural bounds. Toni acknowledged the culturally normative high expectations from family but stressed to clients that negotiating them is a developmental process, adding: "individualization, it's a Western concept, but it happens in Asia too."

Summary of Results

The therapists reported similarities in their conceptualization and treatment of clients across cultures. However, they viewed Asian American clients as being under considerably more pressure to be thin and to achieve. They cited gender role, filial piety, collectivism, and a cultural norm of conforming as influential. While both parents and daughters appeared to idealize Western beauty norms, intergenerational acculturative stress created communication problems and struggles with autonomy. EDs offered a way of coping by emotionally disconnecting or expressing distress covertly. The therapists paid particular attention to shame, even as they worked to challenge both mainstream U.S. and traditional Asian norms. Psychoeducation and including parents in the treatment plan, although not always successful, was viewed as critical.

Discussion and Implications for Practice

The present study provides insight into Asian American women clients with EDs through the perspectives of their therapists and adds to the extant literature by exploring how experienced therapists perceive and work with cultural concepts in ED treatment. As noted by APA's (2006) Presidential Task Force, clinical expertise and consideration of cultural contexts are important aspects of evidence-based practice.

Striegel-Moore and Bulik (2007) asserted that although the etiology of EDs is exceedingly complex, the risk of developing ED symptoms (in mostly White samples) increases with factors of *thin-ideal internalization*, *dieting*, and *body dissatisfaction*. Although similar risk factors are seen across ethnic groups, little is known about whether certain issues place non-European American groups at particular risk (Smolak & Striegel-Moore, 2001). Therapists in the present study described their clients as primarily impacted by common risk factors that are shaped by cultural norms in important ways.

The therapists stated that their clients experienced inordinate thin idealization and body dissatisfaction, and most believed that Asian American women experience greater familial and cultural pressure to be thin than do other women. Parents strongly encouraged thinness, perhaps influenced by the belief that it is key to their daughters' success in the U.S. (as suggested by Ting & Hwang, 2007); some also encouraged plastic surgery. A number of clients disliked their faces to the point of body dysmorphia. The inability to meet the dominant culture's definition of beauty may contribute to Asian American women's vulnerability to EDs (Yokoyama, 2007); the present study suggests that distress over facial features may be a specific risk factor for some.

Smolak and Striegel-Moore (2001) stated that acculturation should be studied as a possible unique risk factor for ethnic minority women. The research on acculturation is conflictual, indicating that the more acculturated to Western culture, the greater likelihood of EDs; and conversely, the less acculturated, the more *cultural conflict and stress*, and the greater likelihood of ED (Smolak & Striegel-Moore, 2001). The present study seems to support the latter, as all the therapists reported that the majority of their Asian American clients with EDs were first and second generation. Many of these clients were still very much in the stressful process of acculturation, receiving the following messages: adapt to the U.S. mainstream through professional success; conform to Asian gender standards; do not embarrass family by being other than very thin; and attract the best possible mate. Most relevant to family relationships was the acculturation difference between daughters and their parents, resulting in a conflict of values.

Although acculturation stress was salient, ED behavior in these clients may also have been impacted by norms within their culture of origin. Indeed, although BN appears to be a more recent and more Westernized phenomenon, there is evidence of purposeful starvation among adolescent girls across the world (including Asia) for centuries (Keel & Klump, 2003); and EDs are now increasing in affluent societies in Asia (Lee & Katzman, 2002). Furthermore, while little research suggests Asian Americans are actually at greater risk for EDs, Kawamura (2002) speculated that collectivistic values (e.g., the individual represents the group) may exacerbate body dissatisfaction in some Asian women. The data from this study would seem to support that: therapists generally believed that there was a connection among ED behaviors, body dissatisfaction, the desire for surgery, and the desire to fit in. This suggests that the meaning of thinness for some Asian American women may involve deeply rooted beliefs of honoring the family through one's presentation and achievement, particularly in the process of adapting to the U.S., and conforming to both cultures in such a way that one does not stand out.

Most experts agree that full-syndrome EDs involve more than body dissatisfaction and the desire to be thin. Reviewing case-control studies, Schmidt (2002) reported that genetic predispositions to thinness and personality traits of "perfectionism, obsessionality, negative self-evaluation, and extreme compliance" (p. 249) are likely risk factors for AN, as are more general psychiatric factors, such as childhood trauma. Likely risk factors for BN

include childhood and parental obesity, criticism about weight and eating, dieting, and other psychiatric problems. Although many of these are considered genetic or personality traits, culture can shape how they are experienced and demonstrated. Smolak and Striegel-Moore (2001) stated that "Levels of perfectionism, need for social approval, and family relationships may vary by ethnicity in ways that have implications for the development of eating disorders" (p. 120). The present study suggests that indeed, while therapists believed their clients experienced these same factors, the realities of conformity, filial piety, and collectivism were intertwined with perfectionism and need for social approval; and intergenerational cultural strain impacted family relationships.

It is not clear whether Asian American women are more prone to one type of ED versus another, an issue made more complex by the fact that DSM diagnoses for EDs have questionable utility for non-Whites (Franko, 2007) and that so many people receive the "not otherwise specified" diagnosis. Recent studies have shown no differences in rates of restricting, binging, or purging across ethnic groups (Franko et al., 2007; Shaw et al., 2004), and that Asian Americans are similar to other groups in that lifetime prevalence of BN appears greater than AN (Franko, 2007). However, there is some evidence that Asian American women show slightly more restrictive behaviors than do other groups (Wildes et al., 2001) and lower rates of purging (Regan & Cachelin, 2006). Therapists in the present study referred almost equally to cases of AN and BN, but a larger number were characterized as "restrictive." This may suggest that Asian women are more prone to AN, or it could suggest that subclinical behaviors in Asian women are more likely to be restrictive. Wildes et al. (2001), for example, posited that cultural factors, such as the pressure to be thin, may play a larger role in subclinical behaviors, whereas full-syndrome EDs likely require bio-genetic and family factors. While restrictive behavior appears to be congruent with a number of cultural norms, research is needed to determine whether they are more common in Asian Americans, or a more common pathway to a full-syndrome ED, and whether they in fact lead to AN more than BN.

EDs can be viewed as attempts to manage distress and difficult mood states (Connors, 1996; Costin, 1999). Costin summarized some of the "adaptive functions" (p. 65) of EDs as: *comfort*, *numbing*, *cry for help*, *discharge of anger*, and *predictability and identity*. Mediated by cultural factors of emotional restraint, collectivism, and filial piety, therapists in the present study related their clients' EDs to culturally congruent coping strategies. Whether in response to more overt dysfunction such as abuse, or to more normative intergenerational conflicts, therapists believed that some clients—unable to talk back, unable to understand the seeming lack of affection, unable to freely express emotion or desire—simply shut down emotionally. A few therapists referred to EDs as expressions of distress that did not go against cultural norms (i.e., starving or vomiting is less disrespectful than talking back). Although the U.S. research is scarce, researchers in Asia (e.g., Lee, 2001; Pike & Borovoy, 2004) have also conceptualized EDs as attempts to manage family stress and societal change while still maintaining gender role norms.

ED treatment is still evolving. Feminist theory has undeniably influenced current approaches (and is arguably most interested in the influence of culture); and psychodynamic therapy has a long history in ED treatment (Stein et al., 2001). Empirically supported treatments are dominated by cognitive–behavioral (CBT), interpersonal (IPT), and Dialectical Behavioral Therapy (DBT) (Stein et al., 2001). Outside of research centers, therapists report using a variety of approaches to EDs (see Simmons, Milnes, & Anderson, 2008). Similarly, with the exception of one who identified strongly as psychodynamic, most therapists in the present study described integrative methods. Although their approaches differed and were tailored to the individual, their work was congruent with what many experts have asserted to be crucial: help clients regulate affect, improve interpersonal functioning, challenge rigid cognitions, and experiment with new behavior. All of the therapists conformed to established guidelines for treatment (e.g., American Psychiatric Association, 2006) in terms of utilizing multidimensional care and ensuring safety.

There is, of course, research on cultural competency in counseling Asian Americans (e.g., Tewari & Alvarez, 2009); however, little research connects culturally relevant practices to specific disorders. Therapists in the present study had to learn a good deal from their clients, and although very experienced, were humble in the face of the many challenges. Most conformed most closely to a *cultural accommodation* approach (see Leong & Lee, 2006), in which important cultural concepts are integrated into established treatment methods. Many interventions reported were consistent with recommendations made by authors who have written theoretically about treatment with Asian American women with EDs (e.g., Ting & Hwang, 2007; Yokoyama, 2007). For example, many of the therapists employed CBT strategies in response to their clients' negative beliefs about their faces and challenged the culturally loaded thinness ethic, and some specifically attended to internalized racism and discrimination experiences. Results were mixed, however, particularly when parents were strongly reinforcing those ideas.

Psychoeducation emerged as a central method of helping, and required cultural knowledge and nuance. It was crucial to reducing the shame of seeking help and to eliciting cooperation from family. This is consistent with demonstrating *credibility* and providing a *gift* (something concretely helpful), important alliance-building techniques with traditional Asian Americans (Lee & Mock, 2005). Moreover, psychoeducation was how therapists respectfully began to challenge parents about issues of acculturation, autonomy, and communication, and it was critical when family and cultural norms appeared to overtly harm clients. As Lee and Mock (2005) advised, most of the therapists avoided overt confrontation. The Asian American therapists who employed the most vigorous efforts on behalf of their clients' greater autonomy still worked in a nuanced manner.

The most striking finding was in fact the degree to which therapists included parents in treatment, regardless of the age of their clients. This was not always successful, but it appeared crucial to the cases that did go well. Although family visits are often included in intensive outpatient and inpatient programs (Costin, 1999), and others have suggested that family therapy is suited to clients from collectivistic cultures (Stein et al., 2001; Ting & Hwang, 2007), the present study is the only one we know of that describes Asian parents' involvement in treating EDs. Perhaps the most important clinical skill here was flexibility and openness to, for example, seeking out the one parent who was more accessible, or permitting unorthodox arrangements such as a mother sitting in on sessions, even as issues of autonomy were being addressed.

In summary, tentative clinical implications can be drawn from the experience of therapists who saw fruitful work using the following methods: carefully building rapport through sensitivity to cultural norms, inviting the participation of parents of adult clients, helping families negotiate acculturation stresses, and challenging both Asian and U.S. mainstream cultural norms regarding beauty and gender role. There is concern that clinicians do not assess ethnic minority women adequately (Franko et al., 2007). Given that therapists in the present study were at times surprised by an ED well into treatment for another issue, and that clients not only presented with textbook EDs but also with issues such as extreme distress about small amounts of weight gain or facial features, clinicians may want to relinquish preconceived notions and more routinely inquire about eating behavior and body image in first- and second-generation women. Being prepared, culturally prepared, to educate clients and their families about EDs appears crucial.

Limitations and Directions for Future Research

The results and implications of the present study are preliminary and descriptive, and must be considered in light of a number of limitations. Qualitative methodology does not allow for generalization in a quantitative sense; therefore, the therapists in the present study cannot be considered representative of therapists in general (or of those who work in research settings with specific therapeutic protocols), and the clients referred to in the study are not a representative sample of Asian American women with EDs. Although we had a relatively diverse mix of therapists in terms of professional experience and cultural background, all were from the West coast. Their experience may reflect trends in immigration to the West coast and this may be why many clients referenced were first and second generation; the results of this study may not be applicable to people more strongly acculturated to the U.S. Furthermore, conclusions about clients and treatment must be tempered with the fact that this study relies exclusively on the perceptions of therapists and did not include client outcome measures or input. Given the design of the study, it cannot speak to "best practices." Nevertheless, we believe the therapists were remarkably open about their work and that practitioners will benefit from their experience.

This study highlights numerous areas for future research. Further study of first- and second-generation Asian Americans seems particularly warranted and researchers will need to find culturally appropriate means of soliciting clients to participate in research. It will also be important to study specific groups (e.g., Korean Americans) because they have different immigration patterns, exposure to Westernization and globalization, and values (e.g., collectivism may not look the same across Asian groups). The idea that thinness is a part of a more general norm of conforming is also worth pursuing, given the indication of a strong thin ideal internalization. More is needed on the impact of racism and discrimination. Body dysmorphism and restrictive behaviors may be important risk factors and need further study. Finally, research on education and prevention in Asian communities is highly warranted.

Carefully tracked cases with periodic assessment of clients, and long-term follow-up would be useful in qualitative studies with therapists. Interviewing Asian American women who have recovered from an ED would provide an additional lens. Finally, research centers studying empirically supported treatments could work on cultural accommodations to their models, actively solicit Asian American clients, and include cultural details in their published reports.

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