Todos Comemos: An Interpretative Phenomenological Analysis of Rural Hispanic/Latina Women Diagnosed with an Eating Disorder

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Author Note

I have no conflicts of interest to disclose.

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Abstract

Eating disorders are incredibly impactful and can be detrimental to the livelihood and health of those who are diagnosed with one. As racial minority populations continue to grow in the United States, research must continue to explore the impact mental health has on people coming from different backgrounds. Latinos/Hispanics are one of the largest minority groups in the country (Gándara, 2015; Gearing et al., 2024; Passel et al., 2011), so in order to maintain both validity and inclusivity within psychological literature, there must be efforts made to continue research on ethnic minorities. For the purpose of clarity and consistency, and despite there being different origins, it should be noted that Latinos and Hispanics are terms that are used interchangeably throughout this particular paper (Martínez & Gonzalez, 2021). The purpose of this study was to answer the question, "How are rural Hispanic/Latina women, who are diagnosed with an eating disorder, affected by culture, community, and treatment options?" Using a qualitative approach, six participants were recruited and asked to fill out a demographic questionnaire and complete a semistructured interview with the researcher. Several themes were gathered from the interviews including the impact family has on those diagnosed with an eating disorder, the way culture may impact both the development and recovery of an eating disorder, community/cultural norms, treatment options and the impact rural living can have on someone seeking treatment for an eating disorder. Findings from this study have the possibility of providing much needed insight into a community that is often underserved and overlooked. Future research should continue to explore cultural factors that impact mental health in order to expand literature on rural Hispanic/Latina women.

Keywords: Eating disorder, qualitative methodology, Hispanic, Latina, rural

Chapter 1: Introduction

For many years there was a misbelief that eating disorders only impacted European or white American women (Cachelin et al., 2014; Reyes-Rodríguez et al., 2014; Smolak & Striegal-Moore, 2001), but as more research has been done on the prevalence of eating disorders in multicultural populations, it has become increasingly clear as well as accepted that eating disorders impact racially and ethnically diverse populations as well (Patmore et al., 2019; Talleyrand, 2012). Latinos/Hispanics are terms used to describe a group of people who have Cuban, Mexican, Puerto Rican, Central or South American, or any other Spanish descent, while Latinas is a term to describe females only (Martínez & Gonzalez, 2021). Despite improvements being made on diverse research, Latinas are among the most underrepresented minority groups in eating disorder literature (Talleyrand, 2012). Between 1980–2010, the number of Latinos in the United States grew from 6.4% (14.6 million) to 16.3% (50.5 million) and this number is expected to continue to rise and become the largest minority group in the country (Gándara, 2015; Martínez & Gonzalez, 2021; Passel et al., 2011).

A large percentage of Latinos reside in rural areas of the country (Passel et al., 2011; Stacciarini et al., 2015) so as the population of Latinos in the United States has continued to grow at a rapid speed, the need for greater use of mental health care within this population is growing as well (Kouyoumdjian et al., 2003). The motivation behind this study was for researchers to not only investigate Hispanic women who are diagnosed with an eating disorder but also to take it a step further to evaluate the lived experience of Hispanic women diagnosed with eating disorders who are living in rural areas of the United States. Rural populations often experience a lack of accessibility, options, and coverage for mental health care (Larson et al., 2016; Smalley & Warren, 2012); therefore, areas of residence can greatly impact one’s ability to find affordable treatment and can cause recovery to be a much more complicated and longer process (Lenardson et al., 2010). Additional factors that negatively impact rural populations to seek out mental health treatment include stigmatization, distance to services, the fear of dual relationships, and limited or under-insured treatments available (Pepin et al., 2009; Taylor & Ruiz, 2017; Wagenfeld, 2003).

Eating Disorders

Although the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) listed more than three types of eating disorders, the present study focused on anorexia nervosa, bulimia nervosa, and binge eating disorder. According to an 8-year longitudinal study on the threshold and subthreshold of eating disorders among a sample of adolescents, researchers found that out of 496 adolescent girls, 5.2% of them met criteria for anorexia, bulimia, or binge eating disorder, and 13.2% of girls suffered from an eating disorder by the time they were 20 years old when including nonspecific eating disorder symptoms (Stice et al., 2009). Eating disorders have been said to be the second deadliest mental health disorder, exceeded only by opioid addiction (Chesney et al., 2014).

Bulimia Nervosa

According to the DSM-5, bulimia nervosa is a feeding and eating disorder characterized by the following symptoms: a period of binge eating accompanied by compensatory behaviors including the use of diuretics, fasting, self-induced vomiting, and excessive exercise that occurs at least once a week for a period of three months (American Psychiatric Association, 2013). This mental disorder is commonly associated with low self-esteem or poor body image and a preoccupation with appearance and general body shape and weight and has detrimental impacts towards one’s mental and physical health (Hoek, 2016; Raevuori et al., 2015); however, due to the intensity of bulimia nervosa, this disorder is frequently accompanied by a range of physical complications that can be short term, long term, or in the worst cases, life threatening (Leonidas & Santos, 2017; Patmore et al., 2019).

Common complications of bulimia nervosa include nausea, intestinal sensitivity or disorders, the loss or altered menstrual function, gestational diabetes, inflammation or destruction of the esophagus, hair loss or hair growth, deterioration of teeth, gum disease, changes in sleep, increased probability of substance abuse, lower levels of body mass index, increase in suicidal ideation, low energy, and pregnancy complications (Leonidas & Santos, 2017; O'Brien et al., 2017). According to an 8-year longitudinal study that followed 496 adolescent women in the United States, the rate of bulimia nervosa was 1.6% at age 20 (Stice et al., 2009).

In a study conducted in the United States in 2011, the prevalence of bulimia nervosa was said to be between 1.3% and 0.5% among teenage women and men ranging from age 13–18 years old respectively (Swanson et al., 2011). Bulimia nervosa was said to have a mortality rate of 3.9% (Crow et al., 2009) and a suicide rate of 31.4% (Udo et al., 2019). These rates were significantly higher than previous studies which was hypothesized to be due to inadequate screening for bulimia nervosa and general mortality or mortality due to suicide being reported as a result of substance abuse, depression, and other factors often comorbid with bulimia nervosa (Crow et al., 2009).

Anorexia Nervosa

Anorexia nervosa is a mental disorder characterized by a fear of gaining weight paired with disturbances in eating habits with the purpose of maintaining or losing weight and having an inaccurate or skewed perception of one's body shape and size (Rikani et al., 2013; Saunders et al., 2023). This eating disorder is especially harmful and risky due to the medical complications that accompany it, making it one of the deadliest psychiatric disorders (Chesney et al., 2014). Weight is usually lost by extreme restriction, intense physical activity to burn calories, and the misuse or overuse of laxatives or diuretics (Fairburn & Harrison, 2003; Mehler et al., 2022). In addition to the mental disturbances anorexia nervosa causes, malnutrition can lead to a plethora of physical health concerns such as cardiac complications, gastrointestinal issues, blood issues, and more (Keski-Rahkonen et al., 2007; Mehler et al., 2022).

Due to the extreme dangers of anorexia nervosa, some cases require somatic care in a hospital or medical setting. Admittance into a hospital is especially crucial when there has been severe malnutrition or medical complications that require medical assistance. In a study conducted by the National Comorbidity Study Replication (Hudson et al., 2007), the lifetime prevalence of anorexia nervosa in adults was found to be 0.9% in women and 0.3% in men. In another study with a sample size of 9,282 Americans, findings also stated that 0.9% of women and 0.3% of men reported having had anorexia during their lifetime (Keski-Rahkonen et al., 2007).

Binge Eating Disorder

Binge eating disorder is an eating disorder characterized by recurrent episodes of overeating and feeling as though you have a lack of control, usually resulting in rapid eating, feelings of discomfort, eating when not hungry or past feeling full, eating alone, and feelings of disgust, shame, and depression following an episode (Kornstein et al., 2016; Raevuori et al., 2015). This is different from bulimia nervosa and anorexia nervosa due to the absence of any compensatory behaviors such as misuse of laxatives or diuretics, over exercising, or purging. In Hudsen et al.'s (2007) study, of the 9,282 Americans who were asked about their mental health conditions, 3.5% of women and 2.0% of men had binge eating disorder during their lifetime, making binge eating disorder more than 3 times more common than both anorexia nervosa and bulimia nervosa combined. Despite the high prevalence of binge eating disorder, and being the most common eating disorder, it has remained one of the most underdiagnosed and undertreated mental disorders (Kornstein et al., 2016). Along with the psychological impact binge eating disorder has on individuals, it should also be mentioned that there is a number of physical health concerns due to the increase in risk of medical conditions such as metabolic syndrome, diabetes, obesity, hypertension, and dyslipidemia (Kornstein et al., 2016; Raevuori et al., 2015; Stein et al., 2014).

Acculturation and People With Eating Disorders

American or Western culture has often been paired with this desire for thinness which has been commonly perpetuated through celebrities, magazines, advertisements, and Hollywood (Warren et al., 2010). Due to the impact that White American culture can have on one's perception of the so-called ideal body type and overall body dissatisfaction, it is important for researchers to both acknowledge and study the influence Western culture can have on those who come from non-Western ethnic backgrounds (Warren et al., 2010). Acculturation is a term used to describe the process that happens when someone willingly or unwillingly adopts the new (most times dominant) culture that can impact them socially, psychologically, and behaviorally (Ortega et al., 2006; Smokowski & Bacallao, 2006).

The higher level of behavioral acculturation Mexican American women report (including but not limited to eating Westernized diets, watching Western media, listening to Western music, and dressing in Western fashion), the higher level of internalization of Western ideals they had (Warren et al., 2010). The lower levels of behavioral acculturation (including but not limited to eating traditional Mexican foods, watching Mexican media, listening to Mexican music, and dressing in Mexican fashion), the lower level of internalization of Western ideals they had (Warren et al., 2010). Mexican Americans who are not subscribed to Westernized culture are less likely to experience the internalization of the thin body type, and therefore report lower levels of eating disorders such as bulimia nervosa (Warren et al., 2010). Literature has suggested the risk for mental illness within acculturated Latinos may be related to the disintegration of the family unit and strong social support system (Ortega et al., 2006).

Eating Disorders and People of Color

One factor that may be important to consider, especially when exploring the prevalence of eating disorders within ethnic minorities, is the ethnic differences in the clinical presentation of mental disorders. Symptoms such as body image distortion, ideal body weights, comorbidity of depression and anxiety, fear of weight gain, and dietary restraint are all symptoms that do not necessarily always present themselves in all ethnic groups (Gilbert, 2003). For example, African Americans have been found to have lower levels of dissatisfaction with their bodies and report fewer eating disturbances compared to White women (Gluck & Geliebter, 2002; Wildes et al., 2001), and both male and female African Americans have been diagnosed with anorexia nervosa at a much lower rate than white Americans (Walcott et al., 2003).

Despite Asian Americans being one of the largest ethnic groups in the United States (Yu et al., 2019), they have been said to be the least explored minority group in eating disorder studies (Talleyrand, 2012). Asian Americans have been significantly less likely to seek out mental health care than other minorities (Leong et al., 2007) and in similar fashion to Latino Americans (Cachelin et al., 2001), Asian Americans have often been left out of clinical studies concerning eating disorders; therefore, a large majority of treatments have been validated and created with only White Americans in mind (Leong et al., 2007; Tsong & Smart, 2014). U.S. Indigenous peoples (including American Indian/Native American, Native Hawaiian, or Alaskan Natives) are another minority group that has very limited literature regarding prevalence of eating disorders (Striegal, 2011); however, of the few studies that have been done, U.S. Indigenous populations were more likely to report binge eating symptoms than White Americans (Becker, 2003).

Eating Disorders and Latinas

Literature on eating disorders has focused predominately on nonminority women (Cachelin et al., 2014), and because of this lack of representation in the field of psychological research, the misbelief that eating disorders only exist among white women has been sustained and strengthened throughout the years (Reyes-Rodríguez, 2010). This belief is not only detrimental due to its ability to invalidate Latinas everywhere who have been battling eating disorders, but it also raises the question of how many culturally sensitive treatments are available to those who might have been silently struggling (Patmore et al., 2019).

In the past 2 decades, there has been an influx of research dedicated to multicultural populations, including Latinos (Alegria et al., 2007). Research on Latinas has consistently shown they tend to have a higher body mass index than European American women (Saunders et al., 2023) and one study (Granillo et al., 2005) even found that socioeconomic status and higher levels of parental education were factors that significantly related to the presence of symptoms of eating disorders for Latinas. Latinos had a significant rate of eating disorders involving binge eating disorder characteristics while anorexia nervosa was seen to be significantly less likely within this population (Alegria et al., 2007).

Other literature has cited acculturation and older generations of Latinos as having a generally poor or limited insight on what eating disorders even are (Higgins et al., 2016). Some might conclude that the only reason for the lower rates of reported eating disorders in Latino populations is really due to the lack of understanding what eating disorders are rather than the absence of eating disorders within this population (Reyes-Rodriguez et al., 2019). Others have argued that the low rates of reported eating disorders among Latinas is due in part by decades of clinical studies only involving those who were a part of the White American culture (Cachelin et al., 2001).

Latinas With Bulimia Nervosa and/or Binge Eating Disorder

In one study conducted by the University of North Carolina (Neyland & Bardone-Cone, 2019), researchers gathered 43 Latina women who had a history of either binge eating disorder and/or bulimia nervosa to study any possible disparities that may challenge or prevent them from receiving treatment. Each participant was asked to identify what kind of health care professional they had seen for their eating disorder (if any had been seen), asked if they had ever gone through intensive treatment such as residential or inpatient hospitalization, and were asked to rate the helpfulness of any services received on a scale from 1 (*not at all helpful*) to 5 (*extremely helpful*). In addition, each participant was asked a series of questions surrounding barriers to treatment such as whether they believe there to be stigma surrounding eating disorders, if they have shame related to eating disorders or mental health treatment, if they have noticed lack of referrals, financial difficulties associated with treatment, and more.

Lastly, acculturation was assessed by the use of the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000). SMAS is a questionnaire that includes 32 questions meant to assess how immersed an individual is in the dominant culture/society (Neyland & Bardone-

Cone, 2019). Of the 43 participants who were included in the study, 15 (35%) reported they had not yet received treatment and 28 (65%) had received treatment. The most used healthcare professional to treat their eating disorders were psychologists or therapists and nutritionists or dieticians. The barriers that were most commonly identified by participants included stigma surrounding eating disorders, eating disorder shame, shame surrounding mental health, and the cost of treatment. Lastly, acculturation was associated with greater perceived treatment helpfulness. The results from this study may help bring awareness toward the possible barriers Latinas face when attempting to receive treatment for an eating which could improve accessibility, acceptability, and options being made available to them.

Barriers to Seeking Mental Health Treatment

There are many reasons why one might not seek out mental health treatment for mental health services. Factors such as lack of accessibility, stigmatization, misinformation, lack of insurance coverage, distances to services, and the fear of dual relationships are just a few (Pepin et al., 2009). In addition to younger adults of all ethnic backgrounds being twice as likely than older adults to seek therapeutic treatment for mental illness (Robb et al., 2003), younger adults tend to have more general knowledge of a plethora of mental health issues (Pepin et al., 2009). In 2017, 15% of adults over 60 years old endured mental disorders (World Health Organization, 2017); however, older adults underused mental health care at alarming rates (Pepin et al., 2009).

Another barrier that often exists for those seeking mental health treatment is stigmatization. The fear of being labeled or disapproved by society is often a driving force behind underused mental health care services (Corrigan et al., 2004). The term *mental-health-related stigma* includes stigma (defined as mental illness being associated with negative beliefs), discrimination (defined as withholding the rights of people based on their mental illness), and internalized stigma (defined as when the negative beliefs held by others begin to influence one's own thoughts about themself; Corrigan et al., 2014; Hack et al., 2020). In addition to general shame, those who struggle with eating disorders, including body dysmorphic disorder, can sometimes feel as though they do not have a clinical problem and therefore do not need treatment (Phillips et al., 2005; Schulte et al., 2020). Those who struggle with body dysmorphic disorder often are convinced there is something wrong in their appearance and therefore do not feel like mental health treatment is what they are needing, but rather feel like cosmetic or medical treatment is what is needed (Phillips et al., 2004).

Challenges Facing Latina People Seeking Mental Health Treatment

To address the specific needs of Latinas effectively and efficiently, one must understand the challenges and possible barriers that may exist surrounding mental health services (Alegria & Woo, 2009; Kouyoumdjian et al., 2003). One barrier that may exist between this population receiving services is that Latinas may endorse mental health symptoms in a much different way than what many U.S. clinicians may be familiar with (Alegria & Woo, 2009; Wildes et al., 2001). There are certain culturally bound names for specific mental issues such as *ataques de nervios*, which refers to anxiety attack-like symptoms that may not be diagnosable when using standardized testing instruments (Nogueira et al., 2015).

In contrast to the individualistic culture that many Americans hold, Latino people have been known to have more collectivistic ways of living life, tending to prioritize the needs of everyone rather than just being concerned with themselves and their needs (Nogueira et al., 2015; Wildes et al., 2001). This can be an additional barrier experienced by Latinos reaching out for services because traditional therapy is usually only involving one client and their presented issues or goals for treatment. Many Latinos prioritize physical health over mental health, which have been shown in trends of Latinos using medical treatment at much higher rates than mental health treatment (Ai et al., 2014). Older Latino adults tend to seek advice from family primary care doctors rather than mental health professionals and commonly hold the belief that their problems are their own business so there is no need to involve a perceived stranger (Dupree et al., 2010). Other barriers may include socioeconomic stressors because Latinos, especially immigrant Latinos, obtain a greater risk of poverty and limited education that limits the amount of job opportunities they have which impacts their ability to receive health insurance that covers mental health services (Kouyoumdjian et al., 2003; Nogueira et al., 2015).

Mental Health Stigma and Latinos

Despite all the barriers Latinos face when seeking out mental health treatment listed previously, one of the most prevalent and impactful barriers that exists is the mental health stigma that plagues this population (Collado et al., 2019; Mendoza et al., 2015). Hispanics, when compared to non-Hispanic Whites, reported a much larger amount of embarrassment and shame surrounding the presence of mental illnesses as well as negative perceptions associated with antidepressant use (Cabassa et al., 2006; Jimenez et al., 2013). Young Latinos had a higher rate of reporting shame and embarrassment as being the reason for not reaching out to receive mental health care (Dupree et al., 2010), and a significant number of those who drop out of treatment before it was completed reported that stigma had a strong influence on their treatment adherence (Livingston & Boyd, 2010). In one study that aimed to explore the association between Latino generational status, mental health service usage, mental distress, and barriers to the usage of mental health treatment, researchers found first-generation Latino immigrants had the lowest rate of mental health use and were found to have the highest rate of reported linguistic and structural knowledge barriers (Escobar-Galvez et al., 2023).

It should also be noted that many Latinos, especially those who are Mexican immigrants, seek out a specific healing method known as *curanderismo* instead of traditional mental and physical healthcare (Loera et al., 2009). Curanderismo is a term to describe the healing practices that involve the mind, body, and spirit of an individual and has been around for many centuries, in many different traditions, dating back to the 16th century (Loera et al., 2009; Roader, 1988). This approach to healing sometimes involves herbs, dream interpretation, oracles, and hallucinogens (Loera et al., 2009; Parsons, 1931; Zacharias, 2006) and has continued to be used by many. Much of the appeal to curanderos includes the accessibility to rural and small towns, little to no cost for services, informal establishment of care (no paperwork or insurance needed), Spanish-speaking healers, and the familiarity of many of the curanderos to their community and clients (Loera et al., 2009; Zacharias, 2006).

As mentioned previously, many rural Latinos do not have the accessibility, information, and insurance coverage to seek out traditional American healthcare (Pepin et al., 2009), and often feel a sense of shame (Collado et al., 2019), so *curanderos* are an often comfortable and efficient source of healing for many. One study that gathered approximately 500 Latino adults found more than 50% of the participants reported a preference of seeking out help through informal sources of care such as friends, family, coworker, religious affiliates, and faith healers over seeking the help from professionals such as licensed mental health professionals, hospitals, clinics, and other mental health service providers (Gearing et al., 2024).

Several studies have shown participation in psychotherapy and specialized mental health treatment decreases the probably of mental health stigma, and therefore suggests increasing the number of Latinos receiving mental health services may decrease the amount of stigma that surrounds mental health care within this population (Collado et al., 2019; Livingston et al., 2012). When looking at levels of acculturation, research has shown that the more acculturated Latino youth's parents were, the greater probability they would seek mental health services (Galvan & Gudiño, 2021), and greater acculturation in general is correlated to the reduction of barriers to mental health care accessibility due to higher levels of English speaking, better insurance coverage, and higher levels of education (Collado et al., 2019; Vega & Lopez, 2001).

Challenges Facing Rural People Seeking Mental Health Treatment

Rural communities have been found to have three major challenges when it comes to seeking mental health services: availability, accessibility, and acceptability of mental health care (Smalley & Warren, 2012). In addition, many studies have shown that rural communities experience poor mental health at much higher levels than urban communities (Cristancho et al., 2016; Lenardson et al., 2010). Not only are there fewer mental health professionals per capita in rural areas of the United States which create provider shortages (Andrilla et al., 2018; Wagenfeld, 2003), but a large portion of rural population have also limited insurance coverage and, therefore, have little to no options when it comes to mental health services (Fullen et al., 2020). Many rural communities have been labeled as mental health service shortage areas (Rural Health Information Hub, 2019), so the process of ensuring mental health care accessibility is a challenge to many (Fullen et al., 2020; Larson et al., 2016).

One of the main challenges facing rural people seeking mental health treatment has been the limited amount of coverage their insurance may offer, especially coverage on services they have access to in their communities. Medicare, one of the most widely used insurance policies, have their own rules and regulations when it comes to what level of education is required for mental health professionals to be in-network (Fullen et al., 2019). A large proportion of Medicare coverage is dedicated to doctorate-level clinicians, excluding many master's-level clinicians which results in what many refer to as the Medicare mental health coverage gap (Fullen et al., 2019). Forty-seven percent of nonmetropolitan areas (i.e., rural communities) lacked psychologists, whereas only 19% of metropolitan areas lacked psychologists (Larson et al., 2016), which suggests that rural psychologists are limited while master's-level counselors in rural areas are more accessible; however, they are not often covered by Medicare insurance which only exemplifies the disparity that exists within this population (Fullen et al., 2019). Another challenge that rural populations may face at a higher rate than metropolitan populations when seeking mental health services is the possibility of dual relationships and the ethical dilemmas that come with it (McNichols et al., 2016; Warren et al., 2014). Isolation, lack of diverse resources, as well as limited competence with rural mental health professionals are additional challenges that may present themselves (Warren et al., 2014).

Challenges Facing Rural Latino People Seeking Mental Health Treatment

Latinos have been among the fastest growing ethnic minority group in the United States, particularly in rural areas of the country (Gearing et al., 2024; Passel et al., 2011; Stacciarini et al., 2015) and as the numbers of immigrant Latinos within the United States have continued to rise (Gudiño et al., 2011), the exploration of the barriers that exist for rural Latinos seeking mental health care has become more imperative. Several studies have shown that Latino immigrants are at a higher risk of experiencing premigration, migration, and postmigration stressors that can manifest as posttraumatic stress disorder and major depressive disorder (Dixon De Silva et al., 2020; Gudiño et al., 2011; Jaycox et al., 2002).

One school-based mental health program found that recently immigrated Latino youth were at a higher risk for displaying psychopathological symptoms due to violent exposure (Kataoka et al., 2003), and several studies have shown a significant correlation between discrimination and depression (Flores et al., 2008; Lee & Ahn, 2012; Ward et al., 2019). A study done in 2010 found that approximately 35% of Latino immigrants experienced discrimination within the past 365 days (Tran et al., 2010), and the rate of ethnic discrimination occurring everyday among Latinos was 30% (Pérez et al., 2008; Torres & Vallejo, 2015).

Adverse childhood experiences have long been considered a risk factor for increased probability of mental illness, and one study in particular looked at adverse childhood experiences scores of rural Latinos to see if there was the same correlation (Barrera et al., 2019). Results showed that those who received a score of 3 or more on the adverse childhood experiences survey were 8 times more likely to abuse alcohol and other substances, and 3 times more likely to experience longer periods of mental distress (Barrera et al., 2019). Research on the prevalence of substance use and abuse, specifically opiate abuse, has indicated higher rates in rural areas than urban areas (Allen et al., 2019); however, Latinos in general are significantly less likely to use substance abuse treatment due to attitudinal and subjective norm barriers than White and Black people (Pinedo et al., 2018). Latinos have been shown to have less familial support, more stigma surrounding specialty treatment, and avoidance of recovery which all contribute to the overall barriers that exist within treatment for substance abuse (Pinedo et al., 2018). Findings are an area of concern due to the high rates of Latinos inhabiting rural areas (Passel et al., 2011; Stacciarini et al., 2015).

Eating Disorder Treatment and Latina Women

Following the push for more ethnic minority studies within the field of psychology, the push for studies exploring the efficacy of evidence-based treatment on Latino participants has also increased (Shea et al., 2012). Considerations that may be involved when treating eating disorders in Latina women includes level of acculturation, language proficiency, and cultural norms (Patmore et al., 2019). One major influence on Latino culture is food. This cultural emphasis for Hispanics is on traditional food which often includes rice, meat, and very few vegetable options (Jimenez et al., 2015). Within many Latino cultures, food is seen as the main way to gather a family together and is often referred to as factor that defines the Latino culture as a whole (Jimenez et al., 2015; Weller & Turkon, 2015). For these reasons, it may be necessary to include cultural/contextual modifications in treatment as patients begin to disclose how they and their community conceptualize what bulimia nervosa (or any eating disorder for that matter) is (Patmore et al., 2019).

Due to Latino people's common cultural value of family (familismo), it may be important to incorporate family into treatment, such as family-based treatment and interpersonal psychotherapy (Couturier et al., 2013; Patmore et al., 2019). A case study done in 2014 suggested that treatment that is not only culturally sensitive but also incorporates and prioritizes family has a much higher probability rate of outcome success when treating eating disorders in Latina patients (Reyes-Rodríguez et al., 2014). Other studies have shown there is great value in involving family connectedness, ethnic identity, as well as dependence or independence into the treatment for Latinos with eating disorders (Bernal & Reyes-Rodríguez, 2008; Reyes-Rodríguez et al., 2019). Many rural Latina women feel a sense of responsibility toward their family and community and a significant influence from matriarchs in their reported values and behaviors (Stone at al., 2023).

Conclusion

Eating disorders have been among the deadliest mental disorders and can be found to impact anyone, regardless of their ethnic background or area of residence (Chesney et al., 2014; Coren & Hewitt, 1998). What was once a disorder commonly believed to only impact White

American and European women, has now been shown to impact ethnic minorities as well (Cachelin et al., 2014; Patmore et al., 2019). As the rate of Latinos in the United States continues to grow (Gándara, 2015; Gearing et al., 2024; Passel et al., 2011), with a large percentage of these Latinos residing in rural areas of the country (Passel et al., 2011; Stacciarini et al., 2015), the need for research surrounding rural Latino mental health continues to grow as well (Kouyoumdjian et al., 2003). Research on rural communities has shown availability, accessibility, and acceptability of mental health treatment as the three major challenges that confront rural inhabitants (Smalley & Warren, 2012). The motivation behind this study was to answer the question, "How are rural Hispanic/Latina women who are diagnosed with an eating disorder affected by culture, community, and treatment options?"

Rationale and Research Question

The research question that was addressed in this study was: How are rural Hispanic/Latina women, who are diagnosed with an eating disorder, affected by culture, community, and treatment options? The findings from this study have the possibility to provide the field of psychology with further insight into a demographic that is often overlooked and underserved. In addition to the impact both rural living and cultural factors can have on the experience of having an eating disorder, it is becoming increasingly important to study the lived experiences of rural Latinas who have an eating disorder to continue improving the effectiveness and validity of eating disorder treatment (Franko et al., 2012; Johansson et al., 2019). Rural communities are often plagued by several disparities including socioeconomic stress, poverty, illiteracy, lower levels of education, higher levels of chronic health conditions as well as disabilities, and unemployment (Fullen et al., 2020; Smalley & Warren, 2012; Rural Health Information Hub, 2019).

In addition to these challenges, many rural communities have less mental health professionals per capita (Andrilla et al., 2018; Wagenfeld, 2003), despite having higher rates of mental health issues than urban communities (Cristancho et al., 2016; Lenardson et al., 2010). The rationale behind this study was to learn more about rural Latina women who are diagnosed with an eating disorder and possibly bring to the light the need for improved and culturally competent treatment, the need for more rural mental health clinicians, the need for better insurance coverage, the need for advocacy surrounding mental health services in order to destigmatize mental illness, and the need for increasing the number of Latinos who receive treatment for mental health.

Chapter 2: Research Design and Method Section

The research question addressed in this study was: How are rural Hispanic women, who are diagnosed with an eating disorder, affected by culture, community, and treatment options? Specifically, the study focused on finding out if there were differences in treatment options available to rural Hispanic women, if and how culture impacts one's road to recovery, and whether living in a rural community impacts the individual's perception of both mental illness and mental health.

Philosophical Worldview

To investigate the presented research question, an interpretative phenomenological analysis (IPA) was carried out to gain insight into the lived experience of rural Hispanic women who have been diagnosed with bulimia nervosa. The IPA model is a well-known and widely trusted qualitative research approach for obtaining insight into one's lived experiences (Hays & Wood, 2011; Miller et al., 2018). The main purpose of using the IPA model was to understand the way people make sense of certain experiences (Pietkiewicz & Smith, 2014). This approach to research is grounded in three major philosophical underpinnings including phenomenology, hermeneutics, and ideography (Pietkiewicz & Smith, 2014). The phenomenology branch, primarily developed by Edmund Husserl, centers around the investigation of the way people perceive their experience, specifically what makes their experience any different from others (Pietkiewicz & Smith, 2014). It is more so focused on the way people view their lived experiences rather than what they know others describe it as.

Husserl's idea then influenced Heidegger (1962) to develop the hermeneutics (meaning "to interpret" in Greek) branch that further emphasizes the importance of understanding one's lived experience (Pietkiewicz & Smith, 2014). Those studying under this idea are more concerned with immersing themselves into the shoes of others to get the closest to understanding the view as possible (Pietkiewicz & Smith, 2014). Finally, the ideography branch that exists within the IPA approach to research involves a thorough look into all presented cases before settling down to develop a statement that encompasses all. The main objective is to remain neutral throughout the process of investigation so that you can avoid being universal (Pietkiewicz & Smith, 2014). Through this study, I hoped to obtain further knowledge and understanding on the lived experience of rural Hispanic women with bulimia nervosa in order to be better equipped to provide treatment and ongoing counseling to a wide variety of people.

Rationale

Findings from this study provide the field of psychology with further insight into a demographic that is often overlooked. Not only are there rural and cultural factors that may impact the experience of eating disorders in Hispanic women (Franko et al., 2012; Johansson et al., 2019), there also has been a common misconception that Hispanic women do not experience body image issues, harmful eating behavior, or eating disorders (Hitti et al., 2020). These biases have been founded on misinformation and lack of literature surrounding this topic (Shea et al., 2016). Due to rural communities' tendency to be overlooked within mental health care (Taylor & Ruiz, 2017), I believed this study helps bridge the gap in research literature by emphasizing the importance of representing rural Latina women who experience mental health issues. Despite the growing number of licensed psychologists in the United States, the need for mental health care in rural underserved populations has continued to grow exponentially (Johansson et al., 2019). Possible biases included my own lived experience of being a Hispanic female and having had experience living in a rural community for a brief period in my life.

Design and Strategy of Inquiry

This qualitative study used a phenomenological approach to data collection with an emphasis on understanding the way one perceives a common experience (Pietkiewicz & Smith, 2014). Gaining further insight into rural Hispanic women's experience having eating disorders provides direction for future treatment recommendations and considerations involving cultural competence. Data for this study were collected using short questionnaires and semistructured interviews that include both broad to specific questions. The questionnaire in this study included a general demographics questionnaire intended to gather basic information of all participants; all questions in the semistructured interviews were intended to understand the specific eating disorder the participant had, what kind of established care they had, if any, and how they perceived the overall experience of having an eating disorder while in a rural community as a Hispanic woman.

Demographic Questionnaire

As previously stated, the purpose of the demographic questionnaire was to gather general information about the participants to ensure accurate representation. This questionnaire was conducted through Qualtrics. All participants had the option to skip any questions they did not want to answer. Following distribution through email and verbal explanation of the consent forms, participants were asked to complete the questionnaire (see Appendix A).

Semistructured Interview Questions

Following the completion of the demographic questionnaire, each participant began the semistructured interview at their scheduled date and time. All the interviews took place on Zoom; they were recorded using both video and audio for data collection purposes. The interviews all took around 40–60 minutes each, allowing participants to spend as much time answering each question as they prefer (see Appendix B).

Study Procedures

To gather participants, I used opportunity sampling by emailing psychologists and group practices in rural areas of the United States to share my study and hopefully get willing participants. Included in these emails was a flier explaining my study and its purpose, as well as announcing all participants would receive a $25 Amazon gift card as an incentive and thank you for participating in the study. The same flier was posted across several Facebook groups in hopes of reaching more people. In both the emails and social media posts, specific emphasis was placed on participant requirements. Participants had to be 18 years old or older, currently diagnosed with an eating disorder, and a Hispanic/Latina woman, and live in a rural community. It also emphasized the researcher's dedication to maintaining all participants confidentiality and protection. Any interested participants were asked to email the researcher directly in order to schedule an available time.

Due to current Coronavirus risks and precautions, all questionnaires were completed via Qualtrics program online and interviews were done remotely using HIPAA compliant Zoom systems. All willing participants read over and signed a consent form via Qualtrics prior to partaking in the study partaking in the study (see Appendix C). Within the consent form, interested participants were given a summary of the study, the purpose, overall procedures, an explanation that they were able to discontinue at any time, and resources in case they had any emotional reactions to the study and its content. During the time of the interviews, each participant was given an oral summary of the consent form they signed and were reminded that they could stop at any time.

The targeted population included rural Hispanic women who were diagnosed with an eating disorder. The requirements stated previously were the only requirements needed to participate. No attention or penalties were placed on marital status, sexual orientation, developmental or acquired disabilities, and religious or spiritual affiliation of the participants. The IPA structure of research typically involves a smaller amount of sampling due to its focus on in-depth examination rather than broad generalizations (Pietkiewicz & Smith, 2014); thus, the total amount of participants needed for this study included six separate individuals.

Data collection for this study included the demographic questionnaire, the semistructured interviews, audio recordings, and field notes. The purpose of the demographic questionnaire was to collect basic information of all participants to acquire any possible trends or significant differences that exist within the sample. They were also used to ensure all participants met the requirements for the study. The semistructured interview was a collection of open-ended questions used to elicit significant insight into the lived experience of the participant. Audio recordings were used to ensure accurate information was transcribed and interpreted. Following the completion of all interviews, the audio recordings were transcribed and then coded for the best possible accuracy. The field notes were used to accurately depict the overall presence of the participants. Noted within these observations included body language, perceived affect, eye contact, and any other significant impressions.

Promoting Study Reliability and Validity

The study’s reliability and validity were dependent on my own effort to practice with both diligence and ethical conscientiousness with specific attention to triangulation data collection. The best way to ensure validity and reliability within qualitative research is to examine the trustworthiness of data collection, reports, coding practices, and the overall approach with which the researcher conducts their research (Golafshani, 2003). To avoid any biases that may occur during the data coding process, both the researcher and a peer coded the data to ensure inter-rater reliability before any conclusions and themes were finalized (Golafshani, 2003). Triangulation, which is a process that incorporates several techniques of data collection to improve the validity and reliability of qualitative research (Patton, 2002), was used by using questionnaires, interviews, and the field notes. Triangulation helps assist researchers in producing valid and reliable data because it involves a variety of realities using different collection strategies (Golafshani, 2003). Lastly, each participant involved in the study received the transcription of their interview to review, correct, or omit anything in the transcription. Once the reviews were returned to the researcher, coding began.

Protection of Human Subjects

Specific and significant attention was designated to confidential participant recruitment and participation. Once emails were sent to mental health centers and professionals, it was up to their clients or patients to reach out to the researcher to set up a meeting. Any interested participants gathered from the social media posts reached out via email to the researcher to set up a meeting. No communication between the researcher and the participant's therapist, psychiatrist, psychologist, or any other clinical professional ever took place following the initial email. No penalties were given for any recruited interested individuals who withdrew from the study.

All email communication between the researcher and the participants will be deleted by May of 2024. While collecting data, the confidentiality of the participants was kept protected using pseudonyms and only general information was gathered in the demographic's questionnaire. All confidential information gathered through written field notes, transcribed interviews, and audio recordings were kept locked in a filing cabinet in the Northwest University graduate building that only the researcher has access to.

Conclusion

The main purpose of this qualitative and phenomenological study was to explore the experiences of rural Hispanic women who are diagnosed with an eating disorder. Given the specific nature of this study, great effort was put toward gathering eligible participants to ensure the results reflected the specific demographic and subculture. Findings from this study provide the field of psychology insight into a population that is often overlooked and simplified (Franko et al., 2012).

Chapter 3: Results

This phenomenological qualitative research study explored the ways in which rural Hispanic/Latina women diagnosed with an eating disorder were impacted by culture, community, and the treatment options available to them. More specifically, the study was meant to examine any challenges rural Hispanic/Latinas face when living with an eating disorder diagnosis. The purposes of this investigation were to contribute to the body of literature on rural Hispanic/Latina women, a commonly overlooked population, and to understand the challenges those who are diagnosed with an eating disorder face.

A phenomenological qualitative semistructured interview research approach was used to answer the research question, “How are rural Hispanic/Latina women, who are diagnosed with an eating disorder, affected by culture, community, and treatment options?” This approach collected rich and informative data which was then coded with attention to detail.

Data Collection and Coding Procedures

Following the completion of two separate questionnaires via Qualtrics (including both the consent form and the demographics questionnaire), six participants scheduled and attended their interviews via Zoom. Transcripts of each interview were generated through Word and each of the six participants were given the chance to read over and edit any part of their contribution. Once each participant provided approval of the transcripts, all six of the transcripts were uploaded to MAXQDA, a program that allows researchers to code and pull themes from data.

Codes are used in qualitative research to categorize and link together data that share similarities to establish thematic analyses (Gibbs, 2007). Initial codes were developed by using two approaches, line-by-line coding and in-vivo coding. Line-by-line coding was used to gain an overview of the content and pull out any obvious and general themes found throughout the content at first glance. Line-by-line coding is an approach to coding that involves researchers precisely going through each line of the transcript to code or label the content found with the intent of avoiding any possible biases or motives the researcher may have (Gibbs, 2007). Due to humans' natural preconceived ideas and core beliefs, it was imperative that this type of coding be used before any other to avoid prejudices or personal views. In-vivo coding is another form of coding that involves the use of participants own words which can be particularly beneficial when researching a culture or set of cultures (Manning, 2017). This approach to coding allows for meaning to come from the participant's own words rather than anything else.

The second round of coding included using axial coding which is an approach that further tunes the already established codes by categorizing and grouping codes into major codes (Williams & Moser, 2019). The act of grouping similar or related codes together aids in the establishment of themes (Saldaña, 2016). Axial coding was used once initial codes were established to produce overarching themes. Several of the codes were noticeably related to one another so grouping them together helped organize the data retrieved.

Reliability and Validity

In addition to the use of triangulation data collection, reliability of the data collected was made certain by both member checking and the use of a peer coder. Member checking is a process in which participants are given a chance to edit their responses before interpretation is made by the researcher (Birt et al., 2016). Following completion of their interview, audio recording was used to produce written transcripts in Word. Each participant was emailed a copy of their transcript and asked to either reply with "I approve" if they were content with the transcript provided or reply with "Approval pending on the following edits." All six participants provided approval.

A peer coder a peer assigned by the researcher to engage in the coding process on their own to avoid any biases and ensure inter-rater reliability before any conclusions and themes are finalized (Keene, 2020). The peer coder in this study was Jean Thomas, a doctoral candidate who just recently completed their own qualitative dissertation. Thomas was provided with the six transcripts and asked to code the data as well. Similar codes and themes were pulled by both the primary researcher and the peer, further ensuring the reliability of said data.

Participant Demographics

As shown in Table 1, the study group included six participants. Of the six, five reported being between 25–34 years old (83.3%) while one reported being between 45–54 years old (16.67%). All participants (100%) were reportedly an ethnicity of Hispanic/Latino origin and lived in a rural community. Of the six participants, one reported not having been diagnosed with an eating disorder by a healthcare provider (16.67%) while the five others reported having been diagnosed with an eating disorder by a healthcare provider (83.3%). Four of the five participants who were diagnosed with an eating disorder by a healthcare provider were diagnosed more than 1 year ago (80%) while one had been diagnosed 11 months to 1 year ago (20%). Of the five participants who had been formally diagnosed with an eating disorder, three were diagnosed by a primary care doctor/physician (60%) while two other participants had been diagnosed by a mental health care provider (40%). Of the six total participants, two participants reported having been treated in the past (33.33%), while 4 out of 6 participants reported they had not been treated for an eating disorder in the past (66.67%).

Table 1

Participant Demographics

Participant	Age	Race/ ethnicity	Gender	Live in a rural community?	Diagnosed with an eating disorder by healthcare provider	Diagnosis	When diagnosed	Who diagnosed	Treated in past	Currently treated	Primary language in household
1	25–34	Ethnically of Hispanic/ Latino origin	Female	Yes	Yes	Bulimia nervosa	More than a year ago	Primary care doctor/ physician	Yes	No	English
2	25–34	Ethnically of Hispanic/ Latino origin	Female	Yes	Yes	Binge eating disorder	More than a year ago	Primary care doctor/ physician	No	No	English
3	25–34	Ethnically of Hispanic/ Latino origin	Female	Yes	No	Binge eating disorder	I have not been formally diagnosed with an eating disorder	Other	No	No	English
4	25–34	Ethnically of Hispanic/ Latino origin	Female	Yes	Yes	Binge eating disorder	More than a year ago	Primary care doctor/ physician	No	No	English
5	45–54	Ethnically of Hispanic/ Latino origin	Female	Yes	Yes	Binge eating disorder	More than a year ago	Mental health provider	Yes	No	English
6	25–34	Ethnically of Hispanic/ Latino origin	Female	Yes	Yes	Bulimia nervosa	11 months-1 year	Mental health provider	No	Yes	English

When asked if they were currently being treated for an eating disorder, 1 of the 6 participants reported currently being treated for an eating disorder (16.67%) while 5 out of 6 participants reported they were not currently being treated for an eating disorder (83.3%). All six of the participants reported English was the language they primarily spoke at home (100%). Of the six participants, Participants 1 and 6 reported having been diagnosed with bulimia nervosa (33.33%) while Participants 2, 3, 4, and 5 reported having been diagnosed with binge eating disorder (66.67%). For the remainder of this paper, to ensure clarity when a specific participant is being mentioned, each participant will be identified by their number and either BN (bulimia nervosa) or BED (binge eating disorder).

Participant 1 (BN) described being around the age of 18 when she began to wonder if she had bulimia nervosa. She described how she would eat “too much” and engage in purging to relieve herself of feeling “sick.” Participant 2 (BED) shared that when she was younger, she remembered eating to help her constant anxiety. She shared that due to family pressures to eat the food being served, she developed a habit of overeating which resulted in getting bullied by kids at school which then drove her to eat more.

Participant 3 (BED) shared that at age 11 or 12 years old she noticed her appearance a lot more after family members began making comments about her body weight. She described restricting the amount of eating she did in front of others which then, in turn, caused her to isolate and engage in secretive binging. Participant 4 (BED) shared that around the seventh or eighth grade she began to hear other female peers talk negatively about their bodies which caused her to criticize her own body. By the time she was in high school, she began to restrict the amount of food she ate while in school to avoid eating in front of others. She would wait until home where she would then engage in binge eating.

Participant 5 (BED) shared that she was surrounded by food and weight fluctuation growing up. Due to the comments of either criticism or praise made by others concerning her body, she began to go through periods of restricting and then binging, ultimately manifesting into binge eating disorder. Participant 6 (BN) described when she found out she had bulimia nervosa after she began to purge to reduce the anxiety surrounding the feeling of being full. Although this practice started as general anxiety surrounding her body and caloric intake, she then began to feel the need to rid herself of the food she ate.

Analysis of Data

The main purpose of this study was to study the ways in which rural Hispanic/Latina women who were diagnosed with an eating disorder are impacted by culture, community, and the treatment options accessible to them. The research question to be answered was, “How are rural Hispanic/Latina women who are diagnosed with an eating disorder affected by culture, community, and treatment options?” To explore this question, the researcher asked a total of six questions during the semistructured interviews. Through the process of interviewing, four major themes emerged: family impact and support, culture and community, treatment options, and the impact of rural living.

Family Impact and Support

A major theme that was brought up consistently in each of the six interviews was the topic of family—their impact on the participant’s experience having an eating disorder and either the family’s support or lack thereof. Throughout the interviews, participants shared their family customs, opinions on mental health treatment and eating disorders. Although some participants reported having support and understanding from their family, others either had not yet shared their experience with family or their family was not supportive at all (see Table 2).

Table 2

Family Impact and Support

Subthemes	Quotes from participants
Family involvement	Well, it was kind of hard at first. No one knew I was struggling until I began to look a bit different. I was a bit depressed and isolated. I no longer felt as though I was part of the family. There was a time that I thought this was just something I had to live with. My dad loves me very much and so he played a major role in getting treatment for me. My family doesn't really understand it. I feel like the times I have tried to explain my symptoms my parents think it is so easy for one to control them. They simplify it. I guess like there is no real support because there is no understanding. I've kept this very under wraps. Kept it a secret. I think I just told those who I am closer to like my grandma. I am much closer to my grandmother more than my parents so I opened up to her about it once before. I didn't feel comfortable sharing with them (family) any diagnosis or anything… Just because I knew that it wouldn't be taken very well. I wouldn't be supported in that and there would be no interest. I think any eating disorder or even sense of healthy balance is pushed aside or not brought up at all. I feel like if I ever were to bring it up to my mom, she'd be like, oh well you're eating well. I feel like if I were to ever bring it up in the family, it would be kind of a joke or maybe dismissed as, 'oh, you know, you really do have nothing to worry about.' We don't really take mental health too seriously in my family. I just choose not to share too much. I guess I am embarrassed. I think it would be too hard to explain it all to my family. I haven't really shared my eating disorder with anyone really. It's just been something that I've kept to myself.

Subthemes	Quotes from participants
Family comments and criticisms	They are quick to comment on my weight and health, in fact my mom was really pushing for the (bariatric) surgery, but when it comes to how I feel inside, they don't get it.
	I guess I got a lot of comments from family members about my body weight and how I was on the heavier side than most of my other cousins. I guess all those comments started to affect me and so I become more aware of what I was eating.
	I've heard lots of comments from others that made an impact on my body image.
	They are quick to label you as being difficult but not necessarily label you as having a disorder necessarily.
	My mom, although she doesn't know much about eating disorders, she now is careful when it comes to talking about body image and making it a big deal if I ask for appropriate serving size.
Family mealtime	We would stay with my aunt and she would sit us at the table with food and she wouldn't let us get up until we ate the entire plate and everything on it. I feel like that could have led me to feel guilty if ever I threw away food which only increased the anxiety.
	Even if I was full growing up, I would make myself eat because if I didn't it was seen as rude.
	If you go to any family parties like it's kind of rude if you don't eat what they give you.
	Even at family parties. I would eat as little as possible in front of everyone, then get away to eat by myself. I remember the moment I knew I needed help was when I could no longer enjoy eating around friends or family.
	I remember I would always eat until I was painfully full . . . like my mom was very much pushing food, so she encouraged me to eat more. She would always be like, oh, there's more in there, like we don't want leftovers, like, here, have some more.
	In our culture it's almost considered rude if you refuse to eat or to eat more. Eating more makes it known you are enjoying the food being served.
	We're a Mexican family and so there's always food in our in our homes. Every celebration that we have, it's, you know, surrounded by food.
	When it comes to food especially, it is seen as such a positive thing. We place a huge emphasis on food within our culture. A lot of times our families are huge and so are the gatherings which then involve a ton of food.

Family Involvement

Participant 1 (BN) described being around 18 years old when she began to wonder if she had bulimia nervosa. Although her family had not noticed any signs of an eating disorder, she opened up about her struggles to a friend who she then allowed to speak to her father about what she was going through. She reported that although mental health was not something her family spoke a lot about openly, her father encouraged her to get treatment and even helped financially. It was then that her father began to share his observations concerning her isolation and depression. Her father continued to support her in getting treatment, even driving her to and from treatment outside of town.

Participant 2 (BED) reported that although her family was supportive with her receiving bariatric surgery, they were not as understanding when it came to her binge eating disorder or any other mental health challenges for that matter. She described feeling as though her family was quick to comment on her weight and health while having little to no concern about how she felt inside. She reported having had attempted to explain her eating disorder symptoms to her family several times, but they would often simplify it and express their opinions on how easy it would be for them to control it. This left her feeling judged and belittled.

Participant 3 (BED) described having received many comments from family members about her weight and how she was heavier than her cousins. She stopped enjoying eating in front of others and the eating disorder emerged because of this. She reported receiving minimal support or help from her family because they often did not understand mental health challenges. She reported that her family had made comments that she was just too sensitive and that she would get better if she just focused on eating healthier and exercising. When asked if she felt supported by her family, she reported having only told her grandmother about her diagnosis because she was closest to her. Although she did not have any advice or much input on the matter, she listened and told her how much she loved her. She reported not having told her parents due to their past reactions to her depression and anxiety. Overall, she felt like family support was very minimal.

Participant 4 (BED) reported that although her mother did not know much about eating disorders, she became more careful when talking about eating, body image, and serving sizes. She reported that her immediate family had become a lot more vocal with praising and encouraging her when eating healthy and making new recipes. She reported feeling like although her family did not relate or really understand what an eating disorder was and could feel like, they made it a point to support her in any way they can.

Participant 5 (BED) reported that she felt she had no one in her family to talk to about her struggles with eating. She reported that she had always felt that if she brought up having an eating disorder she would be dismissed, or it would be made into a joke by her family. She reported her family often made comments about each other's appearances, weight, and body shape so it was never something she wanted to be vulnerable with. When asked who she had spoken to about her diagnosis, she reported just her husband, a few friends, her therapist, and her primary doctor. She reported not feeling the need to explain it all to her family.

Participant 6 (BN) shared that she had not yet shared her diagnosis of an eating disorder with anyone in her family mainly because of her experience with anxiety. She reported that several years before her eating disorder emerged, she had been struggling with anxiety and her family was not as understanding as one would hope. She spent a significant amount of time explaining anxiety and challenging her family's preconceived ideas and beliefs about mental health, something she did not want to have to do with her eating disorder diagnosis.

Family Comments and Criticism

When on the subject of family, family's comments and criticism were a consistent factor brought up in the interviews. Participant 1 (BN) shared that although her father was supportive of her treatment and recovery, he reportedly made comments about her physical appearance that did not help her self-image. Although his comments could have been coming from a place of concern, she found herself internalizing and obsessing over them. One specific comment made by her father was concerning her face and how she looked thin and sickly, which instead of helping her to recover, secretly encouraged her to keep engaging in purging to continue the weight loss.

Participant 2 (BED) shared her family customs had the idea that one must eat all the food they are served, and if they do not finish, it can be perceived as being rude and ungrateful. She began to feel guilty if she did not finish her meals, which only increased her overall level of anxiety. In addition, as she got older, her mother began to really push the idea of bariatric surgery as a way for her to lose weight, especially after her sister successfully went through with the surgery herself. She reported her family was quick to comment on her weight and health, without considering her mental health.

Participant 3 (BED) reported she began to eat alone away from others after she began to receive comments from family members on her weight. She even began to be called a snob or picky eater by her family due to her opting out of meals. Participant 4 (BED) shared that although her mom was not too familiar or knowledgeable on eating disorders, she became more sensitive and cautious when talking about body image and eating in front of her. In addition, she reported that her mom no longer made comments about her food portion sizes but rather encouraged and praised her for trying out new recipes and eating healthy.

Participant 5 (BED) shared that she had never opened up about her struggles with an eating disorder to her family due to feeling as though it would not be taken seriously. She reported feeling as though her family would make jokes or dismiss her challenges due to a lack of understanding on the matter. When describing her weight "yo-yoing" back and forth (i.e., fluctuating), she reported her family gave compliments and praise when she was seemingly losing weight. Lastly, participant 6 (BN) shared that although she never received deliberate pushback from sharing her initial diagnosis of anxiety, she noticed that most of the reactions from her family members were confused looks and pity. This led her to not open up about her eating disorder due to not feeling completely comfortable sharing something so vulnerable with those who may not even understand it.

Family Mealtime

When on the topic of family and eating disorders, one very apparent factor emerged—the custom of mealtimes within the Latino family system. Participant 2 (BED) shared that she would be sat at a table with food as a child and the adults would not allow the kids to get up until they ate their entire plate. She began to feel a sense of guilt if she was not able to finish her meal, which only increased the anxiety she was feeling. If one does not accept the food that is offered to them, they are automatically seen as rude or ungrateful.

Similarly, Participant 3 (BED) shared that if she did not eat the entire meal offered to her by family, she was then considered rude. She explained further that due to her hesitancy to eat in front of others due to her eating disorder challenges, she has been called a picky eater or snobby by those in her family. They were quick to label someone as being difficult, not understanding that someone could be struggling with an eating disorder. Participant 4 (BED) shared that within her family, her mom was especially very pushy when it came to eating. There was a general understanding that no food was to be left over, and that having two or even three servings was normal. She reported that it is an unspoken rule that you eat what you are served in order to be respectful and grateful.

Culture and Community

Another major theme that was found within each interview conducted included the impact culture and community had on both the experiences of having an eating disorder, and the experience getting treatment. Although this topic was repeatedly brought up in the interviews, it was very apparent that there is still room for growth and education surrounding mental health and eating disorders within the Latino/Mexican culture. Whether it is due to lack of awareness, representation, or resources, several participants shared what it was like getting diagnosed with a mental health disorder as a Latina woman (see Table 3).

Table 3

Culture and Community

Subthemes	Quotes from participants
Awareness of eating disorders	I actually had a feeling I had bulimia nervosa when I was around 18. I was eating too much suddenly and began to purge... At first, I thought I was just sick that caused my appetite to change, but I began purging more and more. I just remember from when I was younger, I've always been more anxious and it caused me to eat more because eating helped my anxiety, or so I thought. Growing up I didn't really know I had that (an eating disorder) I kind of just didn't think about it and people would make fun of me or my mom would comment on my weight and I'd just eat more at night. In college I started to make more friends and I feel like that helped me more in wanting to seek help. I felt like I had enough support to move forward with finding help. It was around maybe like 11 or 12 years old . . . I think I started to notice my appearance a lot more. I started eating more minimally around others and began to eat in my bedroom so no one else saw me or judged.

Subthemes	Quotes from participants
	Probably 8th grade. Middle school. I started being more aware of my body and like other people's bodies and whatnot.
	I remember when I would go to my yearly Wellness checks and the topic of weight or BMI would come up. My doctor ended up saying, I am not 'too overweight' but I could be at a 'better weight.' This was confusing to me as a kid because I wasn't really sure what that meant.
	It took me years to realize that what I was doing was bingeing, let alone that it had a name for it, I just thought I struggled with eating too much and feeling bad about it.
	I just never felt comfortable explaining that I now have bulimia. I don't even know how many of my family members would know what that means.
	I think it took me longer to figure out what was really happening because we don't often get asked about the mental experience you may or may not have with eating. At doctors offices they may ask you if you feel safe at home but they are referring to possible domestic violence or self harm practices. But no one asks you if you feel guilt eating.
	I got to the point of making myself throw up in order to bring myself relief. I remember the first time, I felt a bit of shame but then thought it was only going to be a one time thing. It wasn't soon after though that I did it again. It became a ritualistic habit at that point because I knew it was going to offer me that immediate relief.
Mental health within the community	Mental health is not something we talk about a lot.
	When I was younger I didn't have friends and I didn't really have anyone to talk to so it was harder for me to trust people I guess and openly talk about what was going on in my life.
	I don't think mental health is really talked about much in the Hispanic community.
	There's this common belief within my culture that we don't pay strangers to hear our problems. We don't go out and air out our business. It's looked down upon. We keep it within the family.
	I never really was exposed to mental health and the language that goes with it. My own mental health was never really a priority.
	There are so many women I have run into who, based on their presenting habits, would qualify as having disordered eating or negative body image, you name it. But because we've grown up with stigma surrounding mental health, I don't know if many of them can identify that they might be experiencing an eating disorder.
	I feel like the Hispanic culture is very scared and hesitant when it comes to mental health in general.
	Hispanics tend to feel hesitant when it comes to discussing mental health in general."
Cultural norms	My Hispanic customs makes it hard to not take part in the symptoms of binge eating disorder.

Subthemes	Quotes from participants
	Families are not shy to comment on your physical appearance. They also tend to nick name you based on your physical appearance, whether that's good or bad. In my culture mental health has been so stigmatized. If I was ever experiencing depression, my family would say oh she's just in a mood or she's just feeling bad. Or she's not grateful for all we have. I never felt like I could be vulnerable and actually validate my feelings. There is an expectation for Latinas to be thick but only in the perfect areas. We're expected to have curves, but no stomach, a big butt, big boobs. But some of us just are not made that way. In our community something I often experienced was nick names and 'light teasing' that constantly revolved around one's appearance. I remember my grandma said things that were very impactful that have stuck with me to this day. A big part of our culture surrounds food and family I think it's not talked about in the Hispanic culture and especially in rural towns like where I live in. It is almost like a joke. I almost felt like how am I complaining about eating too much or not liking my body when some people can't even get food on the table. You know?

Awareness of Eating Disorders

Participant 1 (BN) shared that in addition to having limited knowledge regarding eating disorders before she was diagnosed, she also had a family who was relatively unfamiliar with the mental health care field in general. She explained that mental health was not something her family spoke about much. Her family did not listen to her concerns and get her connected with treatment until her bulimia nervosa began to show up physically. She explained that her family started noticing her face changing and becoming thinner to the point of concern as she began to purge more. She explained her dad ended up helping her find treatment only when her community around her began to share her concern.

Participant 2 (BED) shared her belief that Hispanic customs make it hard to not take part in the symptoms of binge eating disorder since food is an essential part of their culture. In addition to this, she shared that in her experience, mental health was not a very talked about topic withing the Hispanic community. She reported more research and education needed to be shared to the community so there is more support and understanding.

Participant 3 (BED) shared her belief that although mental health disorders were prevalent within the Latino/Hispanic community, it was not talked about nearly enough to dismantle biases and myths surrounding mental health. She also shared that there was a common belief within her culture that it is wrong for a person to air out their issues to a stranger in counseling. She reported there was a desire to keep it within the family. When asked about the prevalence of eating disorders within the Hispanic community, she shared a belief that it may be hard to really know because not many people in the community were outspoken about their struggles. The prevalence of eating disorders may be reported as being low; however, that may be only because a few select Hispanic people were coming forward reporting it or even realize that was what they were struggling with.

Participant 4 (BED) reported that within the Hispanic/Latino culture, there tended to be a lot of heavy and high caloric foods with very big portions. Much of the traditional cuisine involves carbohydrates and oils, which in moderation are just fine, but when someone is struggling with binge eating disorder, it could be harder to maintain one's recovery. In addition, she reported having the belief that within the culture, "there is not a lot of concern surrounding weight necessarily but more so a push to be curvy in the right places." She said, "There is an expectation to be thick but not too thick. We are expected to have curves, but no stomach, a big butt, a big chest, but no stretch marks."

Participant 5 (BED) reported that in addition to food being a big part of the Latino culture, there was also a lot of family involvement. She reported feeling surrounded by food and family at all times, making it hard for her to recover. She shared that in her Mexican family, there seemed to always be food being cooked, served, or eaten. She especially felt pressure to cook and serve others due to her being the "go-to" hostess in the family.

Participant 6 (BN) shared that food and eating was often seen as a very positive thing, especially in the Hispanic culture. The belief that mental disorders surrounding eating even exist within the Hispanic community was not widely considered. Furthermore, she shared that family gatherings and the emphasis on food sharing was incredibly prevalent within the culture.

Mental Health Within the Hispanic/Latino Community

Another important factor to consider regarding the topic of culture and community is the overall prevalence and understanding surrounding mental health. Although the rates of mental health disorders may be on the rise within the Hispanic community, the topic not always openly discussed. During the interviews, participants were asked to discuss their perception of how mental health is talked about within their community.

Participant 1 (BN) shared that within the community where she lived, mental health was not frequently talked about, so she felt lucky that she had a friend who both understood mental health and assisted in her getting the help she needed. This friend was seeing a therapist herself, so she was able to use her own experience to help her. This participant described feeling if more people in her community talked about their own mental health struggles, it would be easier for people to acknowledge their mental health challenges and reach out for help when it is needed.

Participant 2 (BED) reported she did not begin to gain more support and the confidence that allowed her to seek out for treatment until she was in college and around more people. She described feeling that within her Hispanic culture and community, no one was open about their struggles, especially with mental health. When asked what could be done to improve cultural norms, she described the older community specifically needed more education on mental health so there are not as many misconceptions being shared.

Participant 3 (BED) shared that she always felt uncomfortable being open about her mental health struggles due to the belief that the community around her would not understand. She held the belief that those around her would believe her issues surrounding depression, anxiety, and disordered eating would be seen as no big deal. She thought that the community would collectively hold the belief that she should just watch what she ate and she would be fine. She also shared feeling hesitant to share her mental health challenges due to fearing being made fun of by others.

Participant 4 (BED) reported that within her community, there seemed to be very little mental health specialists, which left her speaking to her primary care physician about her mental health issues. Her doctor's response was to give her a nutrition pamphlet that explained the food pyramid and offered healthy eating tips.

Participant 5 (BED) reported feeling as though eating disorders were rare within her community, especially when it came to body image issues. She reported having kept her disorder a secret due to fear of judgment because she had not seen a lot of advocacy or conversation surrounding mental health in general. She also mentioned that eating habits and body image issues were not something her primary physician ever brought up on their own. She had to gain the confidence to bring it up to them on her own since it was not discussed often.

Lastly, participant 6 (BN) shared that she believed there were a lot of misinformed ideas surrounding mental health within her community, so she made the decision to keep her eating disorder diagnosis to herself. She reported feeling that despite it not being heavily talked about, she believed the rates of mental health challenges in the community were substantial.

Cultural Norms

When on the subject of culture and community, another factor to consider is the norms surrounding mental health that persist within the culture of Hispanic/Latina people in the United States. Culture norms are practices that are particular to a certain group of people. Whether it is due to passed on traditions, beliefs, or habits, Hispanic people have their fair share of cultural norms.

Participant 1 (BN) reported that mental health was not something that people within her culture talk about much. She explained that it was not until she began to show physical symptoms of her eating disorder that her family began to notice and become concerned. She had been struggling for a while but thought that it was something she had to live with due to the lack of mental health awareness within her culture.

Participant 2 (BED) reported believing there was a need for more education on mental health, especially within the older generation. She explained that within the culture, the younger generation was expected to be respectful and quiet toward elders, so the idea of teaching them about mental health issues, especially eating disorders, seemed like an impossible task. Due to their cultural norms, it would be hard to step out of that and teach elders about what it means when someone is clinically depressed, anxious, or struggling with eating or body image.

Participant 3 (BED) shared that within her culture, it was normal to comment on other's appearance. Whether it was criticism or compliments, it was widely understood that calling out people's appearance was normal. She reported because of this cultural norm, she began to find herself more insecure about eating in front of others. The moment she knew she needed help was when she realized she no longer enjoyed eating among her family, which was another very common cultural norm.

Participant 4 (BED) shared that a cultural norm she noticed as she developed her eating disorder was the big portions of food and her avoidance of seeming rude to the person who cooked the meal. She explained that there seemed to be an unspoken rule of eating one's entire plate when served to come off as grateful instead of rude. It was not until she was living alone when she felt comfortable serving herself more appropriately sized meals and not worrying about eating everything. She began to realize the benefits of having leftovers and listening to one's body when it feels full. In addition, similarly to Participant 3 (BED), Participant 4 explained that within the Hispanic culture, it was very common for one's loved ones to tease them about their physical appearance. Whether that is through nicknames or funny comments about their appearance, comments are often made by those one loves in a lighthearted way. To someone who is already struggling with their body image, these comments and nicknames can be incredibly impactful.

Participant 5 (BED) echoed what Participant 3 (BED) and Participant 4 (BED) stated surrounding the cultural norm of making comments about other's appearances. Participant 5 (BED) shared she was hesitant to talk about her eating disorder diagnosis because her family may begin making comments about her body and the way they perceive it to be. She shared that after years of weight fluctuation, she realized that either way her family was going to make comments. Usually, the cultural norm surrounding weight was the skinner she was, the happier she looked. The fuller she looked, the less happy and less motivated did she look according to her family and others within her culture.

Participant 6 (BN) reported that a cultural norm she experienced repeatedly was the importance of food and food related customs. She explained that food was a big part of her culture, so therefore, it was difficult for her to engage in regular festivities without stressing out about food. She shared her hesitancy with sharing her eating disorder diagnosis to others due to the discomfort of the idea that there are some people who struggle to even get food on the table. She felt a sense of guilt and ignorance when thinking about opening up to those within her culture.

Treatment Options

Due to the rates of eating disorders within the Hispanic/Latina population, another factor one must consider is the treatment options available to them. Within the field of mental health treatment, there has been an emphasis usually on being culturally competent and accessible to those who need it. There has also been a push to be more individualized in treatment depending on the patients' background, needs, and customs. Many physicians and medical professionals have been trained primarily on the nutrition and physical health of a patient, not necessarily on their mental health as it relates to eating and weight. More specialized mental health care has been usually found outside the doctor's office at mental health clinics or therapy offices.

Table 4

Treatment Options

Subthemes	Quotes from participants
Experiences establishing care	I feel like in college I started to care more about my mental health in general and I started making more friends. I've used my insurance, which I have insurance through the state and it's good insurance but the places that it don't have the best counseling available. I have noticed that places that accept my insurance usually have lower quality mental health professionals. I've tried to do counseling or schedule appointments for psychiatry or with a nutritionist um and it's always hard because I don't have the money to be able to afford that without insurance and so it's definitely been hard to access good healthcare. Mental health services in general are very few. The ones that we do have are pretty general treatment and their waitlists are months and months long. So finding even just a counselor to talk to was hard.

Subthemes	Quotes from participants
	What I've been told was that even if you do find a therapist that is accepting new clients, they usually cannot commit to seeing you on a weekly basis because their case loads are so full.
	I would prefer in person, but at this point I didn't really have much of a choice.
	I think the lack of access. . . . There really aren't any options where I'm at, it's just your primary care physician.
	There's just a lot of barriers.
	It was challenging just to find my therapist because I feel like there is a large need for mental health care, especially when COVID hit.
	Waitlists were something I encountered very quickly.
	I've not been able to like successfully find a therapist that emphasizes on like eating disorders.
Culturally competent care	I feel like my doctor just gave me any medication to treat whatever I was complaining about at the time. There wasn't a lot of time spent listening to what was really going on.
	They treated the bare minimum.
	I remember that more times than not the doctor would prescribe medication and never really follow through on checking in to see if it was working or if there were any side effects.
	I went to the clinic here in town and hoped I could get maybe a referral to more specialized treatment. So I went there and right away when I did start talking about like eating habits and stuff like that they immediately wanted to connect me with like a nutritionist or a dietitian, someone like that, rather than treat the mental health side of things.
	My physician was definitely more concerned with my weight. She wanted me to focus on a healthy diet and try out the Mediterranean diet. I also remember a huge emphasis on my BMI.

Experiences Establishing Care

Participant 2 (BED) shared that her options to treatment were limited by her insurance through the state. She reported never being able to pay for counseling out of pocket, so her process of finding a therapist was dependent on finding someone who took her insurance and had availability. Additionally, she shared that because of the physical symptoms of her binge eating disorder, she also required a lot of care from her doctor, which brought its own issues due to limited availability, difficulty contacting the doctor, and limited care specializing in eating disorders. Overall, she shared that most nutritionists and psychiatrists in her area were not in network with her insurance so although their insight would be beneficial in her overall treatment, she had to settle on her primary care doctor and her therapist who was not specialized in eating disorder treatment.

Participant 3 (BED) shared that her journey in finding treatment for her eating disorder was extremely challenging. She shared the difficulties she encountered such as waitlists being months long and finding a clinician who could commit to seeing her on a weekly basis instead of biweekly or even once a month. She eventually settled on a therapist who practiced outside of town who was able to offer virtual therapy. Although she preferred in person services, she reports feeling like she did not have much of a choice.

Participant 4 (BED) shared her belief that there was a lack of access and support in specialized eating disorder treatment. In her experience, she had to settle on the use of her primary care physician to get treatment because there was not one therapist or psychologist in close proximity that was informed in treating binge eating disorder specifically.

Participant 5 (BED) reported she finally reached out for help during the COVID-19 global pandemic. Because of this, she was quickly met with waitlists upon waitlists. She realized there was a large need for mental health care and there were not many options available to her. Due to both safety reasoning and the long commute, she settled on telehealth services.

Participant 6 (BN) shared that although she originally wanted to find someone who specialized in eating disorders, she ended up setting on a counselor who practiced more generally. She reported that the amount of options provided to her, given both location and cost, were very limited. She reported having the belief that the closer a person is to a major city, the more options they will have when it comes to mental health care professionals and treatments.

Culturally Competent Treatment

Another factor to consider when exploring treatment options made available to those who diagnosed with an eating disorder includes culturally competent treatment. As mentioned in many of the participants' interviews, the process for finding specialized eating disorder treatment was difficult, let alone finding treatment that was also advertised as being culturally competent. Culturally competent treatment is a form of treatment that places emphasis on the inclusivity of different cultures. With these participants specifically, it would be important for the mental health professionals to hold a level of understanding of Hispanic/Latino culture and its possible impact on the presentation of eating disorders.

Participant 1 (BN) reported that due to her father's heavy accent when speaking, it was difficult setting up therapy treatment over the phone. She reported feeling like due to her background, including both being Hispanic and a darker complexion, it was more likely she would face discrimination or biases in the medical or mental health field. Although it was difficult to get started, she reported that eventually she was able to get into treatment, meeting virtually for the majority of the time, and she felt as though it was adequate in addressing her needs.

Participant 2 (BED) shared that when she finally reached out for help, her primary care physician was quick to prescribe her with medications to treat the complaints. She reported not feeling as though they really spent the time listening to what she was describing, and it came off as being unhelpful and almost dismissive. She reported that because of her lack of awareness at the time regarding mental health and eating disorders specifically, she did not feel comfortable or equipped to speak up and ask for treatment directly tied to eating disorders. In addition, she reported that at the time of reaching out for help, her mom was present during all the appointments. This made it difficult for her to feel comfortable speaking up and emphasizing the mental impact her binge eating had on her.

Participant 3 (BED) shared her belief that one of the main reasons it took her a long time to finally reach out for help was the belief that people in her culture just do not get vulnerable with strangers. She felt that in her family and culture as a whole, mental health was still stigmatized, and she felt she was unable to be vulnerable and share her feelings. Furthermore, she had the preconceived idea that no mental health professional would understand what it is like to be part of the Latino culture and all the nuances that comes with it.

Participant 4 (BED) reported that she began to try and explain her concerns with body image and possible binge eating disorder while meeting with her primary care physician. Despite her attempts at bringing in mental health concerns, her physician reportedly handed her a pamphlet on nutrition, the food pyramid, and benefits of a Mediterranean diet. There was very little attention given to the mental side of what she was experiencing. She felt as though the physician was more concerned about her weight and diet than the mental disorder she could be experiencing.

Participant 6 (BN) reported that part of her reluctancy to receiving treatment was the fear that the professionals would not understand. She felt that any mental health professional may not understand what it feels like to feel guilty because she was struggling with an eating disorder while there may be others within the same community who are struggling to even eat enough. She felt as though she needed to find a therapist who came from a similar background, so they understood what it was like to come from a family that frequently nicknames each other by physical attributes and commonly criticizes each other out of love.

Rural Living

One of the last requirements to participate in this study was to be living in a rural part of the United States. The main reasoning for this requirement was to study if residing in a rural community had an impact on both mental health awareness and treatment options. Although many rural cities have grown and gained more access to virtual healthcare, some areas have continued to lack advocacy and awareness of mental health and more specifically eating disorders (see Table 5).

Table 5

Rural Living

Subthemes	Quotes from participants
Barriers to treatment	Being in a rural community . . . brings its own challenges, but I think being a rural Hispanic woman also brings about a whole new level of issues as well. Language barriers can be an issue as well. . . . Sometimes speaking another language or even having a heavy accent like my dad can be a barrier. There is always a chance of discrimination or biases presented. Where I live, we of course have neighbors and people around but we don’t have any counselors or therapists. We have to travel for treatment. I think having online therapy has helped though because I can get treatment while at home. Also, when I first started treatment, I could not drive so I had to rely heavily on my dad and work around his schedule to get rides into treatment. I don’t know if it is due to high load of patients, but I will try to call to make an appointment (at the doctors) and they don’t answer for hours. Even if I leave a call back number they almost never call me back. It takes a lot of time and effort to get to speak with anyone from the office. There weren’t many (treatment) options, and we had to find places that accepted our insurance. In fact, there weren’t many doctor offices in town as it was. Because we lived in a tiny town, we had to travel to the next town over to see someone. With the lack of options as well as sharing the same medical professional (with my family), I found it hard to be open and honest. Because the community is so small, everyone knows everyone, so it’s hard to confide in people. You have to be careful who you talk to.

Subthemes	Quotes from participants
	You go to school with the same people, you work with the same people, you go to church with the same people. It’s hard to have secrecy or confidentiality.
	There’s a lack of access to treatment or like professional support is the biggest one because there’s just not anyone that specializes in that. Very little treatment options for mental health, let alone treatment for eating disorders specifically.
	During the worst of my eating disorder, I was only 14 or 15 years old so it wasn’t like I was going to make my mom drive hours to treatment after she already had to commute to and from work. It just wasn’t doable.
	I’m barely getting used to seeing someone virtual but I definitely grew to appreciate it. It would not be possible for me to make the drive out of town to a therapist further out.
	Around here the options are few.
Limits to privacy	Since I would do my therapy over telehealth, on my phone, some of my family started to notice and asked me who I was talking on the phone with.
	My mom would always go with me (to doctor appointments) and I was also a very nervous child so I didn’t like talking and so my mom would have to talk for me. She would always be present in the room with the doctor and so I never wanted to be judged.
	The last thing you want is for your personal information to become town gossip. Here everyone knows everyone.
	This is kind of why even though I would rather have in person treatment, any in person services around here would risk me being seen by people I know. A front desk person could very well be attending the same church as I am.
	Because I live in a small town a lot of the people that still live here, even in, you know, my mid 20s early 30s, we kind of all grew up together . . . so with that being said, I feel like there’s somewhat of like a pressure for me to be able to portray myself as like having it all together.
	I find myself wanting to hide what I am going through because I don’t want others to talk.
	I assume that in a bigger city you can post photos on social media like Instagram and not have to worry about someone running into you in person.

Barriers to Treatment

Participant 1 (BN) reported that she lived around 25–35 minutes from the city. Although her dad pushed for her to see a mental health provider in person, the commute became too much eventually, and she had to start seeing her therapist virtually. She reported being thankful that telehealth was now more widely used because it increased accessibility.

Participant 2 (BED) reported that because she lived in a small and rural town, she and her entire family saw the same doctor. There were not many options when it came to general health, let alone mental health.

Participant 3 (BED) shared that a big reason she sought out virtual treatment was due to wanting to avoid being seen by others she knew. She reported that living in a small rural town means that everyone knows almost everyone. She reported it was hard to keep one's private life private and there are only a few resources for mental health in the area anyway.

Participant 4 (BED) shared that due to living in a rural town, with the nearest city being 45 minutes away, she found herself having to receive treatment from her primary care doctor instead of a more specialized mental health professional. At the time of her reaching out for help, she was also only around 14 or 15 years old, so she had to rely on getting rides to and from the doctors. She felt that driving hours to and from treatment was not sustainable and so unless a she lived nearby a major metropolitan city, she had to settle on what was near and available to her.

Participant 5 (BED) shared that living in a rural area meant there were less options for treatment. In addition, because she reached out for help around the COVID-19 global pandemic era, she had limited options. She reported that she settled on meeting virtually eventually with a therapist who was living in a more populated city.

Participant 6 (BN) reported that within the small rural town where she lived, almost everyone knew everyone. She reported that people she went to elementary and middle school with were still around and kept up with each other. Because of this, she found it hard to feel comfortable sharing her challenges with mental health to anyone due to the fear of being judged. She found herself wanting to hide what she was going through to protect herself from criticism.

Limits to Privacy

A very common theme emerged when asking participants their thoughts on living in a rural area while battling an eating disorder. Most of the participants mentioned a fear or discomfort with the idea of limited privacy due to living in a small town. Although the privacy and confidentiality laws and ethics remain the same in rural areas as compared to populated cities, many rural residents felt that they were more at risk for losing their privacy given the small town where they lived.

Participant 2 (BED) shared that because her mother also went to the same doctor, she did not feel comfortable getting too vulnerable with what she reported in visits. She believed that if her mother or other family members ever found out she was discussing her mental health with someone outside the home, she would cause drama and unwanted attention on herself. Similarly, Participant 3 (BED) shared that due to their community being so small, everyone knew everyone, which made it harder to confide in others. She reported feeling the need to be careful who she talked to about personal information due to the fear of it becoming town gossip. This was part of the reason she decided on virtual treatment so she could avoid any unnecessary run ins with those she knew. She reported that a front desk person could very well be someone who attended the same church as her, so that was why she elected to keep everything as separate as she could help it.

Participant 6 (BN) shared that she felt a lot of pressure to keep up an image in the community where she lived. Due to the fact that she grew up with most of the people around her, she felt the need to mask her eating disorder and seem like she had everything together. She found herself wanting to hide and avoid running into others while out in public to completely evade the possibility of her personal life being found out. Reflecting on her recovery journey, she realizes just how nervous she was of her personal information being spread around others.

Summary

This phenomenological qualitative research study was conducted with the intent to study how rural Hispanic/Latina women experience being diagnosed with an eating disorder. The data were collected through the use of a demographic questionnaire; semistructured interviews; and the use of several coding procedures including line-by-line coding, in-vivo coding, and axial coding. In addition, reliability of the data was ensured by using both member checking and a peer coder. The major themes that emerged included Family Impact and Support, Culture and Community, Treatment Options, and Rural Living. Within these four major themes, smaller subthemes emerged, providing even more data related to the lived experiences of rural Hispanic/Latina women diagnosed with an eating disorder.

Chapter 4: Discussion

This qualitative study provided insight into how rural Hispanic/Latina women who are diagnosed with an eating disorder are affected by culture, community, and treatment options through the exploration of their lived experience. Findings from this study can provide the field of psychology with further information into a demographic that is often overlooked and underserved. By understanding this population, people are given the opportunity to learn more about the needs and gaps in treatment being made available to them. Furthermore, this study serves as a springboard for further research into rural Latinas, culturally competent treatment, increased accessibility, and the need for further advocacy surrounding mental health services.

Family Impact and Support

Following the completion of all six interviews, several major themes emerged. One main theme was Family Impact and Support, or lack thereof. Many Latino families value *familismo,* a term used to describe the closeness Latinos have to both their immediate and extended family (Ayón et al., 2010; Parsai et al., 2009). It is deemed normal to have a sense of pride and responsibility to be there for one's family, despite the function or dysfunction that may be present. When a member of a Hispanic/Latino family is struggling with mental health, it is important to consider how their family is either supporting or not supporting them in their treatment.

Saunders et al. (2023) showcased how Latinas with an eating disorder experience the impact of culture on their recovery. In Saunders et al.'s study, they conducted 17 separate semistructured interviews inquiring about the lived experience of Latinx/Hispanic women in eating disorder recovery; several themes emerged such as the impact family has in promoting positive recovery outcomes once there is a general understanding and destigmatization of eating disorders, as well as the negative impact Latinx/Hispanic beauty standards have on women's self-esteem as they are in recovery.

Family Involvement

Existing literature has shown that family involvement and general closeness has positive impacts on mental health (McQueen et al., 2003). More specifically, one study looking at the impact *familismo* had on Latino family mental health found that *familismo* decreases rates of substance abuse and child mistreatment and can be characterized as a protector against negative mental health outcomes (Ayón et al., 2010). Furthermore, research has shown that family closeness can have both protective and risk factors when it comes to the mental health of Latino adolescents (Lawton et al., 2018). Lower levels of depressive and conduct disorders were related to having higher rates of supportive involvement, acceptance, and secure attachment from parents (Bámaca-Colbert et al., 2010). Other protective factors for children's mental health includes open and honest communication, parent involvement, and parental monitoring (Bámaca-Colbert et al., 2010; Davidson & Cardemil, 2009; Samaniego & Gonzales, 1999). In contrast, family conflict has been shown to be a risk factor in adolescents leaving them more susceptible to anger, misconduct at school, substance use, anxiety, depression, and more (Gonzalez et al., 2006; McQueen et al., 2003; Pasch et al., 2006; Smokowski & Bacallao, 2006).

Family Comments and Criticism

There has been research showing weight-focused conversations have an association with damaging outcomes in the weight stigma literature (Berge et al., 2023; Lydecker et al., 2018; MacDonald et al., 2015; Pudney et al., 2019; Puhl, 2020; Puhl et al., 2020). A systematic review by Gillison et al. (2016) found that overweight/obesity, dieting, maladaptive weight control habits (e.g., use of diuretics, binge eating, restricting meals) and low psychosocial well-being (e.g., depression, anxiety, low life satisfaction, low body image, low self-esteem) were all correlated to weight-focused conversations (Balantekin et al., 2014; Bauer et al., 2013; Berge, 2009; Berge et al., 2013, 2018; Davison et al., 2010; Eisenberg et al., 2003, 2006; Fulkerson et al., 2007; Hanna et al., 2006; Lydecker et al., 2018; McCormack et al., 2011; Neumark-Sztainer et al., 2010). These findings show that conversations, comments, and criticism made by anyone, especially family members, can be very impactful on one's body image and if applicable, their eating disorder recovery. Many of the participants in the current study shared that their family made comments on their bodies and eating habits, either supporting or criticizing them. One participant shared that her family was quick to comment on her weight and health, and her mom even pushed the bariatric surgery she ended up getting. Another participant shared that comments her grandmother had once made about her body image during childhood has stuck to this day.

Family Mealtime

Most participants shared that eating and food was a huge part of their culture. Food is often considered a main component of familial systems as well as cultural customs for Latinos (Weller & Turkon, 2015). The act of cooking and feeding one's family is a custom commonly passed down by generations within a Latino home (Lindsay et al., 2011). Many Hispanic women find pride in being able to provide their loved ones with food, and therefore, rejecting or limiting the consumption of the food offered is often seen as being rude or ungrateful.

Many participants shared that they felt a sense of pressure to eat not only everything on their plate, but also to accept second servings when eating among their families. One participant shared that if she did not eat as much as she was being offered, she was automatically considered rude by her family because they interpreted it as her not enjoying the work put into the cooking of the food. She reported feeling as though people within her culture were commonly judged and seen as a picky eater or snobby if they did not accept all the food ever offered to them.

Culture and Community

Due to the impact family, culture, and community has on Hispanic individuals, it is important to consider the influence they have on Hispanics/Latinos diagnosed with an eating disorder. Research has shown how familial distress and conflict can be a contributing factor to the development of an eating disorder in adolescents (Bi et al., 2017); however, there has also been research outlining the negative influence eating disorders can have on the adolescent's family (Blondin et al., 2019). Whether or not a community can recognize or empathize with eating disorders is another important factor to look at when exploring lived experiences of women diagnosed with an eating disorder. Factors such as the general awareness of eating disorders and what they are, mental health within the community, and cultural norms all were themes derived from the six interviews.

Awareness of Eating Disorders

During the semistructured interviews in the present study, participants were asked to describe how their family and community reacted to their diagnosis of an eating disorder. One of the main reasons for this line of questioning was to gather information regarding the awareness surrounding eating disorders and mental health in general by those who surround the participant. Two of the six participants shared their experience being diagnosed with an eating disorder while coming from a background where mental health is not commonly spoken about. Participant 1 (BN) reported that she herself did not know a lot about mental health prior to her diagnosis, let alone her family and community. She went on to describe how it was only when she began showing physical symptoms of her eating disorder that her parents and family members noticed she was struggling.

Participant 3 (BED) shared her belief that although mental health disorders are prevalent within the Latino/Hispanic community, it is not talked about nearly enough to dismantle biases and myths surrounding it. She went on to report that it is not common for people within her community to share their personal struggles with those outside their family, so it is hard to know how mental health is experienced by others. In one study, researchers investigated what factors contributed to the prevention of engagement and retention of Latino/as in eating disorder treatment (Reyes-Rodríguez, 2013). Factors such as lack of information about eating disorders, lack of bilingual education or treatment of mental health, stigma surrounding mental health disorders, fear of being misunderstood, privacy of their family, and readiness to change were all mentioned in the findings.

Other participants in the present study, such as Participant 2 (BED), shared that being Hispanic actually made it challenging not to develop binge eating disorder. Participant 2 shared that because food was an essential part of her culture, it was hard not to feel pressure to eat more than you would like to. Participant 4 (BED) reported that because high caloric and heavy foods are a custom within the Latino cuisine, eating a lot of carbohydrates and oils was normalized and even encouraged. She reported that although weight was not a huge concern within her community, there was pressure to be thicker in the “right areas.” She reported believing that if her family and community knew more about eating disorders, they would be more sensitive when it came to eating and body image talk. Participant 6 (BN) shared that the belief that mental disorders surrounding eating even exist within the Hispanic community was not widely considered.

Mental Health Within the Hispanic/Latino Community

When looking at mental health more generally, not just eating disorders, special attention should be placed on how the Hispanic/Latino community both experience and talk about mental illness, as well as the prevalence of mental illness among them. Despite the Latino population growing substantially in the United States, there has continued to be an apparent lack of mental health treatment use within the Hispanic/Latino community. Although Participant 1 (BN) shared that despite her community not often talking about mental health concerns, she felt lucky enough to have a friend who both understood mental health and assisted her in getting treatment. Participant 3 (BED) shared her feelings of discomfort with being open and honest about her mental health struggles. She reported feeling nervous that those around her would minimize or devalue her experience. She reported believing that mental health within her culture was heavily stigmatized and gave examples of times when her family interpreted her depression as just being in a sour mood or being ungrateful, and that the diagnosis was dramatic and unnecessary.

Participant 5 (BED) reported that she chose to keep her mental illness a secret from her family and community due to fear of judgment because there has never been much support or advocacy surrounding mental health within her community. This left her to rely on her husband and primary care physician, losing out on the opportunity to gain even more support from loved ones. Participant 6 (BN) shared her belief that there was a lot of misinformation on mental health within her community, so she decided to keep her diagnosis private. There has been research showing the higher the level of stigma surrounding mental illness, the less likely participants were to reach out for help. One study that specifically looked at the relationship between Latinos and mental health stigma and found that Latino college students who reported high levels of stigma were less likely to reach out for mental health treatment (DeFreitas et al., 2018; Mendoza et al., 2015).

In addition, when compared to African Americans and European Americans, Latinos had higher levels of reported embarrassment concerning their mental illness that was likely tied to their fear of dishonoring their family or shame (Jimenez et al., 2013). Many of the participants in the present study expressed that the fear of judgment kept them from talking to their family about their diagnosis and path to recovery. A very common misconception and generalization within the Latino community includes the belief that anyone seeing a therapist or taking psychotropic medication is “crazy” and often treated and seen as an outsider (Interian et al., 2007). Research has shown that ethnic minorities such as African Americans and Latinos have lesser rates of seeking out treatment (Interian et al., 2013), have lower rates of retention once in treatment (Sue et al., 1995), and have higher probability of waiting until their symptoms are debilitating before they begin treatment (Sue et al., 1994).

Cultural Norms

Almost every participant in the current study mentioned cultural norms that either positively or negatively impacted their experience being diagnosed with an eating disorder. Participant 2 (BED) shared her belief that mental health is not commonly talked about within the Hispanic community. After being diagnosed with binge eating disorder, she began to realize that there was a fine line between a normal cultural custom and a symptom of a mental disorder. She reported that growing up, binging was basically encouraged and if one did not eat until uncomfortably full, they were offending the cook. Participant 3 (BED) shared that if a person does not eat what is being offered by family members, they run the risk of being labeled difficult or ungrateful. In addition, when asked about the prevalence of disordered eating within the

Hispanic/Latino community, Participant 3 (BED) shared that she believed it must be common because a cultural norm with Latinos is to comment on other's appearances, both negatively and positively. She believed that joking and making fun of people's insecurities can have tremendous consequences on someone's self-image.

Participant 4 (BED) shared that when she was growing up, being fuller and chunkier was seen as positive because it suggested people were being fed well. As she grew into adulthood, she noticed the pressure to then become curvy but skinny in the right places. The shift in body ideals from childhood to adulthood were said to be drastic and challenging to achieve. She reported believing that the "light teasing" she received from her family played a huge part in her lack of self-esteem that eventually resulted in her issues with eating. Existing literature on Latino obesity has shown that family member's perception of weight and health can be categorized as a risk factor for childhood obesity (Chaparro et al., 2011). In addition, Hispanic parents have been shown to have a higher probability of viewing their overweight or obese children as healthy and commonly perceive their children as being well fed (Hales et al., 2017; Foster et al., 2016).

Another study (Martinez et al., 2017) aimed to address the beliefs Latino mothers have about child weight and obesity to encourage more culturally competent weight-control programs that understand and work with parent perceptions of feeding habits. After conducting four focus groups with Latino mothers of elementary school-age children in San Diego, California, Martinez et al. (2017) found the following themes: mothers' cultural beliefs that prevent positive family health, mothers' role as being primary caretaker in Latino households, and attitudes about targeting children's weight. They found that although mothers were aware of the misperception that 'chubby is better,' they were still expressing a preference of having a 'chubby child' because it meant they were being fed well. Studies have found that during childhood, Latinas are encouraged to gain weight and eat well; however, there is a shift that happens once they enter adulthood and weight loss, and thinness is promoted by family and friends (Franko et al., 2012). Existing literature suggests that a person's self-image and perception of their body is much more influenced by cultural norms than their actual physical weight/health (Ayala et al., 2007). This directly relates to what participants in the present study described when speaking about the influence their culture played in the onset of their eating disorder.

Treatment Options

Given the prevalence of eating disorders within the United States across any and all ethnic backgrounds and places of residence, treatment options must be considered. Factors such as types of treatment, cost of treatment, approaches to treatment, and accessibility to treatment were discussed in the present study's six interviews. In existing literature, underuse of mental health care by Latinos has been said to have a correlation to financial and health insurance reasons (Keyes et al., 2012) as well as Latinos having a sense of distrust towards medical professionals that decrease their belief that mental health treatment will be effective in treating their issues (Barrera & Longoria, 2018).

Experiences Establishing Care

Every participant in the present study was asked how they were diagnosed with an eating disorder and their experience establishing care. Participant 1 (BN) shared that she struggled with binging and purging for months before her father noticed. She reported that it was not until she began talking to her father and good friend that she realize what she was experiencing was in fact an eating disorder. Participant 6 (BN) knew that she was struggling with keeping food down (to the point of digesting), but she figured it was due to her generalized anxiety. She was not diagnosed with an eating disorder until she began to describe the ritualistic habits to her therapist who then pieced together what might be happening.

Other participants such as Participant 4 (BED) shared that when they sought out help from their primary care physician, more emphasis was placed on their physical health like weight and body mass index than their emotional health. Instead of inquiring more information on her mental health, the physician gave her a pamphlet on the Mediterranean diet and the food pyramid, suggesting she lose weight. Existing literature has explored clinical presentation of eating disorders amongst the Hispanic population with findings that contradict one another (Patmore et al., 2019). In one study, Hispanics were found to be more likely to diet and have higher rates of reported fear surrounding gaining weight (Rodgers et al., 2017) while another study found that Hispanics were showed to have lower risk of dieting, exercise, and concern about weight gain (Lee-Winn et al., 2016). In another study that looked at the lived experience of Latinas in eating disorder recovery through the use of the photo-elicitation method (i.e., participants sharing photographs and discussing their meaning during an interview), researchers found that due to the stigma surrounding mental illness within their culture, they did not feel comfortable discussing their struggles with others (Saunders et al., 2023). In addition, researchers found that most participants described feeling as though their families could not recognize or even understand the signs and symptoms of eating disorders, so reaching out for treatment can be a very vulnerable step for a lot of Latinas (Saunders et al., 2023).

Culturally Competent Treatment

It is important to consider what treatments are offered to those with eating disorders and, more specifically, treatments that consider ethnic and cultural backgrounds. When looking at a specific cultural group such as Latinos, various factors can play a part in how they will receive and react to mental health treatments. Factors such as family involvement, stigmatization, misinformation, and specialization are all important to consider.

Although treatments such as cognitive behavioral therapy (CBT) have been shown to effectively treat eating disorders (Shea et al., 2012), existing literature has questioned the efficacy of CBT with the Latino population. In one study that looked at cultural considerations for treating Hispanic patients with eating disorders, researchers found that CBT programs can be an effective approach if there are specific attempts at modifying it to include family involvement and cultural norms (Patmore et al., 2019). It is essential to include values and customs that Hispanic/Latinos share when treating eating disorders, especially family connectedness, ethnic identity, and dependence/independence (American Psychological Association, 2013; Bernal & Reyes-Rodríguez, 2008).

Out of the six participants interviewed in the present study, two participants shared that they had their family support in their recovery and treatment process while the rest either described doing it on their own or having not told their family about their diagnosis. Almost all participants in the present study mentioned how difficult it had been treating their eating disorder while being Hispanic due to the importance of food and mealtimes within their culture. Participant 5 (BED) shared that, within her Hispanic family, there is always food being served and eaten. She reported that her family was always celebrating something, and celebrations involved meals. Participant 2 (BED) shared that a common cultural norm within her Latino family was the unspoken rule of eating all a person is served and offered. She shared that, growing up especially, she knew that if she denied food or second servings, she would be considered rude or disrespectful toward the person who cooked the food.

Existing literature has covered the impact Latino culture can play on eating disorder recovery, especially given family customs that usually involve overeating and frequent events and celebrations that involve eating (Patmore et al., 2019). Special consideration should then be prioritized when treating Hispanic individuals who are recovering from an eating disorder since their culture can have an impact on their recovery journey.

Rural Living

The last requirement to participate in this study was to be living in a rural area. The main reason for this was to explore the impact rural living had on mental health treatment and more specifically eating disorder treatment for rural Latinas. As mentioned previously, Latinos are one of the fastest growing racial/ethnic minorities within the United States (Kouyoumdjian et al., 2003), and rural communities in the United States have continued to attract more Latino immigrants (Auman-Bauer, 2015). As such, further investigation surrounding best mental health practices is pivotal in maintaining multicultural literature and support. Living in a rural community can have various negative impacts including less healthcare options, higher rates of obesity, increased mental stress, and increased substance use (Agunwamba et al., 2017; Caldwell et al., 2016; Stone et al., 2022).

Barriers to Treatment

Participants in the present study were all asked to describe how they believed living in a rural community impacted their eating disorder treatment. Participant 1 (BN) described feeling disheartened due to the lack of options where she lived. She reported feeling lucky that she had her father who not only financially supported her treatment, but also drove her outside of town to attend therapy. Participant 2 (BED) shared that her options for treatment were heavily impacted by her state insurance. She reported noticing that the places that accepted her insurance usually had what she claimed to be lower quality mental health professionals. She reported the facilities were usually outdated and the waitlists were extremely long.

Participant 4 (BED) shared that after consulting with her primary physician about her disordered eating concerns she was given nutrition pamphlets and encouraged to lose weight. She reported feeling like the physician was more concerned about her physical health than her mental health. Participant 5 (BED) shared that, in the beginning, finding treatment was challenging due to two factors—she lived in a rural small town a half hour away from the nearest city and it was during the COVID-19 global pandemic. Because of this, she had since started to see a therapist via telehealth.

In one article published by the University of Minnesota (Jensen et al., 2020), researchers conducted semistructured interviews of eight mental health professionals who practiced in the rural United States to increase understanding of barriers that may exist for rural communities. Several themes emerged including rural culture, general treatment options, availability, accessibility, acceptability, and stigma. Researchers in this study found that often times the rural culture involves very little trust with medical professionals and a “do it on your own” type attitude that leaves little room for reaching out for help (Jensen et al., 2020). In addition to high caseloads and limited availability, the professionals interviewed shared feelings that there are lack of resources including both referrals and specialists in mental health they can offer to clients. This barrier can cause delays in treatment, low retention rates, and worsen outcomes. Similar to what some participants from the present study mentioned, the rural mental health professionals mentioned the cost, transportation, and distance to mental health care as being a strong barrier to many rural communities (Jensen et al., 2020). Lastly, stigma surrounding mental health care was discussed. Attitudes from family, friends, and community can have a huge impact on the rate of mental health care use.

Limits to Privacy

The last subtheme that was brought up by participants in the present study included limits to privacy while living in a rural community. Due to the fact that rural communities are normally smaller in size, there is a high chance that a person may see people they know when out in public. In the study conducted by the University of Minnesota, privacy was listed as one of the deterrents that many rural individuals face when reaching out for treatment because there is a lack of anonymity where they live (Jensen et al., 2020; McNichols et al., 2016). Some mental health professionals in that study even referred to it as living in a "fishbowl" because everyone knows everyone, and rumors and gossip get around fast.

Participant 2 (BED) shared that even though there are privacy laws protecting her health information as an adult, she still did not feel comfortable speaking about her eating disorder with her primary physician since her mother and other family members see the same doctor. Participant 3 (BED) shared that because her community was so small, she believed that everyone knew everyone, so it was hard to confide in people. She shared that a person must be careful who they talk to about their personal issues because it can quickly spread. Participant 6 (BN) shared that she still lived in the small town she grew up in, so she knew a lot of the other community members. She reported feeling a sense of pressure to maintain her image of "having it all together" because she has been known for that. She reported feeling as though her approach to receiving treatment was a lot slower due to her fear of judgment from others.

Limitations and Future Directions

Clinical Implications

Rural Hispanic/Latina women diagnosed with an eating disorder may be a very specific subgroup; however, due to the rising rate of Latinos in rural areas of the United States, research on their lived experience can produce rich insight into a population that is often overlooked and underserved. It is crucial to understand both the Latino and rural Latino culture and its impact on mental health, mental health care use, barriers of treatment, and treatment options. The main goal of the present study was to explore how Latina women experience having an eating disorder while living in a rural area. This insight can foster more effective approaches to treatment, address any barriers to treatment, increase treatment retention, and much more.

Familismo, a term used to describe the importance of closeness in Latino families (Ayón et al., 2010; Parsai et al., 2009), is an important factor to consider when diagnosing a Latina woman with an eating disorder. Although their physical symptoms and triggers may be similar to White women, Latina women value family closeness and dependence on one another. When a Latina woman is diagnosed with an eating disorder, she will either be supported by her family or not. Both can have an incredible amount of impact on their recovery. For several of the participants in the present study, they felt that due to their family's comments and criticism, they did not want to share their diagnosis with family members. Other participants reported that although their family did not necessarily always understand mental health, they did support them with their diagnosis and helped out in any way they can. That included being more sensitive and cautious with comments regarding body image and food, financial support for therapy, providing transportation to and from treatment, and an openness to learn more.

In addition to familial ties, Latina women also face specific cultural customs that may or may not impact their onset and recovery of their eating disorder. Many participants in the present study reported that family mealtime was an incredibly important and consistent ritual that often challenges their eating habits and outlook. Furthermore, there seemed to be a level of acceptance and encouragement for children to be on the fuller side because the sense of pride that comes with being able to provide your family with hearty meals. Special considerations should be made about Latina women with eating disorders because they may be coming from a background where eating is the way they connect with their family. Factors such as overeating, larger serving sizes, and limited vegetables can all impact the way a Latina woman perceives and challenges their eating disorder.

In terms of culture and community, findings from the present study and existing literature highlight the importance of advocacy and awareness of mental illness, mental health, and eating disorders within the Latino community. Although there has been progress made to increase awareness and education surrounding mental health within the Hispanic/Latino community, there is still very apparent gaps in information made available to them. Latinos have been shown to exhibit hesitancy when it comes to trusting healthcare workers, especially ones that focus on behavioral health. Multiple participants in the present study reported they came from families that held the belief that people keep their issues to themselves or within their family, the belief that strong work ethic will get people through anything, and an expectation of being grateful for the life one lives rather than complaining or being sad. All of these beliefs run the risk of limiting the awareness of mental health issues and treatment resulting in lower rates of use and retention in mental health treatment for Latinos. Levels of misinformation and stigmatization can be challenged by there being more information being made available to the Latino community about mental health and the treatment options available to them.

When looking at treatment options made available to the Hispanic/Latino community, several factors may play a part in what is being offered. This may include pricing, insurance coverage, language proficiency, and cultural competence. Due to the specific cultural customs that Latina women often hold, it may also be important for clinicians to incorporate some of the cultural norms into the approaches to treatment in order to promote culturally competent treatment. Culturally competent treatment is treatment that takes into consideration the ethnic background and customs the individual comes with. It realizes that not everyone comes from the same background and therefore, treatment should not be considered one size fits all. It is important to offer culturally competent mental health care because often times ethnic minorities were not the primary population treatment programs were designed for.

Lastly, the present study highlights the impact living in a rural area of the United States when dealing with an eating disorder as a Hispanic/Latina woman. Rural communities have long been shown to have disparities when it comes to mental health care accessibility and acceptability, specialized treatment, wide range of providers to choose from, and more. It was very apparent in the six interviews from the present study that rural Latina women have been faced with even more barriers when it comes to accessing mental health care. Along with the stigma that still surrounds mental illness, rural Latinas often are met with long waitlists, limited options to choose from, difficulty maintaining privacy and anonymity, long commutes to and from treatment, and little to no coordination of care. It is important for future clinicians in rural areas to prioritize normalizing treating rural residence in a supportive and confidential way. As multiple participants in the present study mentioned, virtual telehealth services have been a great resource for them as they do not live near a big urban city where the treatment options are usually located.

Strengths and Limitations

Analyzing the strengths and limitations to the present study is imperative when it comes to the reliability and validity of the findings. Qualitative phenomenological studies are already interpretative in nature, so it is even more important to assess the strengths and possible weaknesses of a research study. Some of the present study's strengths include the fact that each of the six participants reported they had been diagnosed no less than 11 months to 1 year prior to this study. This meant that they were all new to their recovery and therefore it can be assumed that they had accurate recollections of their experience.

In addition, participants were interviewed by a fellow Latina which could have played a role in them feeling comfortable to talk and be vulnerable due to the familiarity they felt. Another strength is the fact that participant recruitment was open to any resident of the rural United States. According to one article (Coughlin et al., 2019), 14%–19% of the United States lived in rural counties, approximately 46.2 million to 59 million people. Because of this, participants in this study were able to be recruited from all over the country rather than from one specific area, making findings from this study more general and reflective of Latinas from different rural communities, and not just one.

Limitations to this study included the small sample size of six women. Given the vast information one participant can provide a research study, the more participants a study has, the more information and conclusions can come from it. Although not intentional, of the six participants, all but one was within the 25–34 age range. It may be worth further investigation into generational differences to see if age is at all correlated to their lived experience.

In addition, there were no questions regarding participant's degree of acculturation. Acculturation is a term used to describe the process in which immigrated families become accustomed to the new culture in which they inhabit. None of the interviewed rural Latinas were asked their generational status and how long they had been living in the United States. There may be an opportunity for further investigation and getting even more specific than they already were.

Lastly, although information was gathered through the eyes of those living through this experience, it may have been beneficial to interview the family of the participants to get their outlook and opinions on the matter. Retrieving the opinions and experience from the participants is of course the primary concern; however, by not allowing outside perspectives into the data, the themes and conclusions being drawn from it all could be limited.

Future Research

The Hispanic population within the United States is already one of the largest and fastest-growing racial/ethnic groups and is expected to represent 25% of the population of the United States by 2050 (Cabassa, 2007). Because of this, it is of vital importance that research continues to improve the competence, effectiveness, and accessibility of mental health treatment for Hispanic/Latino people. The present study aimed to explore the lived experience of rural Hispanic/Latina women diagnosed with an eating disorder and found that family, culture, community, treatment options, and rural living were all important themes throughout the findings.

There are several directions future research could take in order to expanse the research surrounding Latina mental health. One idea would be to further investigate how cultural customs impact the presentation of certain mental illnesses. During the interviews of the present study, it was apparent that culture played a huge part in how the Latina’s eating disorders were developed, noticed, and treated. It may be worth investigating further so primary care physicians, therapists, psychologists, psychiatrists, and other health professionals have a better understanding of mental health within the Latino community. In addition, another main factor that was considered in the present study was rural living and its impact on mental health and mental health treatment. Throughout the interviews of the present study, it became clear that rural communities face a collection of difficulties that can and do impact mental health. Further research can focus on the impact small communities have on the stigmatization of mental illnesses, the barriers faced when seeking treatment, and suggestions to improve privacy and comfortability with receiving mental health treatment.

A common thread throughout the interviews of the present study was a call for further education and awareness of mental health issues. Future research can focus on discovering ways to reach rural communities to expand resources and knowledge about mental health. Whether it is researching the most effective way to spread awareness or implementing mental health curriculum into schools and work settings in rural communities, further research has the power to impact the lives of many rural Latinos.

Conclusion

In conclusion, the present study explored the lived experience of rural Hispanic/Latina women who were diagnosed with an eating disorder to elucidate this often marginalized and overlooked population. Due to the specificity of the participants gathered for this study, multiple conclusions were drawn from the data received. Latina women are a population continuing to grow in the United States, and because of this, special attention should be placed on their mental health needs and trends.

Throughout the interviews culture and ethnic identity were often discussed having an impact on the perception and presentation of mental illness. Cultural factors such as family support, family traditions, mealtime, critical comments, and norms were all discussed. Many participants reported they did not feel comfortable sharing their eating disorder diagnosis with their family due to experience dealing with their comments and criticism surrounding their bodies, physical appearance, and eating habits.

Many of the participants reported believing their families had little to no understanding or experience with mental health and mental health treatment. More than one participant reported it is frowned upon within their family to deny food that is offered by others. Many reported that if they denied food or even second servings they risked being seen as ungrateful or picky. Participants reported their family normalized overeating and those who struggled with binge eating disorder or bulimia nervosa disorder had an especially hard time during mealtimes around family.

In addition, each participant reported living in a rural area of the country. Rural communities face their own specific hardships and barriers to treatment that differ tremendously from urban settings. The impacts rural living has on treatment availability, accessibility, acceptability, and options made available were all discussed in the interviews.

The main themes pulled from this present study align with existing research that is focused on culturally competent mental health care, rural mental health, and eating disorders within the Latino community. Further research should focus on exploring more culturally competent approaches to eating disorder treatment and spreading awareness and education on eating disorders within rural communities.

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Appendix A

Demographics Questionnaire

1. What is your age?
2. What is your race/ethnicity? Check all that apply:
    a. Hispanic/Latino origin
    b. White/European American
    c. Black/African American
    d. Asian
    e. American Indian/Alaska Native
    f. Native Hawaiian/Pacific Islander
    g. Aboriginal
    h. Other: ____________
3. What is your gender?
    a. Male
    b. Female
    c. Prefer Not to Answer
4. Do you live in a rural community?
5. Have you been diagnosed with an eating disorder by a healthcare provider?
6. When were you diagnosed with an eating disorder and which eating disorder were you diagnosed with specifically?
7. Who diagnosed you with an eating disorder?
8. Have you been treated for an eating disorder?
9. Are you currently being treated for an eating disorder?

10. What language do you primarily speak at home?

Appendix B

Semistructured Interview

1. Can you describe the process in which your eating disorder emerged and when you decided to reach out to treatment?
    a. How old were you when the symptoms of an eating disorder first began?
    b. How did you decide it was the right time to seek treatment?
2. What has been your experience being a Hispanic/Latina woman with an eating disorder?
    a. Do you think your culture or ethnic background had any impact on the presentation of your symptoms?
    b. Do you think your culture or ethnic background plays a role in how others view your eating disorder?
3. Can you explain your experience finding treatment for your eating disorder?
    a. Was it easy finding treatment that fit your needs and accessibility?
4. How did your family, friends, community respond to your eating disorder diagnosis?
    a. Do you feel supported by family or friends?
    b. How prevalent do you believe eating disorders are in your community?
5. How has your view of mental illness and mental wellness shifted since receiving the eating disorder diagnosis?
    a. What was your view of mental health before the diagnosis? Has it changed since being diagnosed with an eating disorder?
6. How do you perceive the eating disorder symptoms you experience when compared to the eating disorder symptoms white females may experience?

7. What are the challenges or difficulties associated with living in a rural area while battling an eating disorder?
    a. What has your experience been like living in a rural area and dealing with an eating disorder?
8. What has been your experience finding appropriate and accessible treatment and/or medication for your eating disorder?
    a. Are there any barriers you have found with treatment or therapy due to living in a rural area?

Appendix C

Todos Comemos: An Interpretative Phenomenological Analysis of Rural Hispanic/Latina Women Diagnosed with an Eating Disorder

Northwest University
College of Social and Behavioral Sciences

Consent Form

Welcome to Todos Comemos: An Interpretative Phenomenological Analysis of Rural Hispanic/Latina Women Diagnosed with an Eating Disorder, a research study that looks at the lived experience of rural Hispanic women who are living with eating disorders. This study is being conducted by Nicole Lemos, a student at Northwest University.

To qualify for participation, you must be an adult age 18 or older. Completion of this study typically takes approximately 1-2 hours and is strictly confidential. Your responses will be treated confidentially and will not be linked to any identifying information about you. If you agree to participate in this study you will complete questionnaires regarding: demographic information (including age, race, gender, area of living, diagnosis of an eating disorder, treatment history, and language), and a semistructured interview that will include questions regarding any challenges you have faced being a rural Hispanic women with an eating disorder, your experiences with treatment accessibility and success, as well as other questions regarding the overall experience of having a mental disorder in your area of living. All data collection and submitted survey information will be password encrypted and stored on a password encrypted hard drive. Both the principal researcher and the secondary researcher, Jean Thomas MA, a doctoral student also from Northwest University, have received human subjects training to protect confidential participant information. In order to avoid any biases that may occur during the data coding process, both the primary researcher and the secondary researcher will code in order to ensure inter-rater reliability before any conclusions and themes are finalized. If you agree to participate in this study you will complete the interviews via Zoom and agree to be both video and audio recorded so the researchers are able to transcribe the interview and collect information regarding body language, perceived affect, eye contact, and any other significant impressions. All data forms, audio, transcripts, video recordings, and information will be destroyed by May 2024.

The Northwest University Institutional Review Board has approved the study. No deception is involved, and participation in this study poses minimal risk to participants, although some participants may experience emotional distress when answering questions that relate to your experience with an eating disorder diagnosis, your experience as a rural Hispanic seeking mental health care treatment, and more. If content of this questionnaire causes you significant distress, please contact the National Eating Disorders Association Helpline at 1-800-931-2237, the crisis hotline at (800) 273-8255, or local services such as NUhope Community Counseling Center at (425) 889-5261. In addition, please utilize the Psychology Today mental health provider directory (https://www.psychologytoday.com/us) in case you feel the need to change providers or talk with a new one. Participation in this study is voluntary, and you may elect to discontinue the questionnaire at any time and for any reason. You may print this consent form for your records. By submitting the survey, you are giving permission to use your responses in this research study.

The results from this study will be utilized for dissertation, publication and/or conference dissemination and may be presented within a variety of psychological forums (formal and informal).

All participants will be receiving a $25 Amazon gift card as an incentive and thank you for participating in the study. You can expect to receive a digital Amazon gift card via email following the completion of your participation in the study. Once the primary researcher emails out the gift cards, all communication between participant and researchers will be deleted in order to maintain confidentiality.

If you have any questions about this study, please contact the principal researcher, Nicole Lemos at XXXXX@northwestu.edu. If you have further questions, please contact my faculty advisor Dr. Kim Lampson at XXXX@northwestu.edu, or the Chair of the Northwest University Institutional Review Board, Professor Cheri Goit, at XXXXX@northwestu.edu or XXX-XXX-XXXX.

Before beginning the survey, please read this consent form in full. If you understand all information contained in this form and agree to freely participate in this study, please click the "I Agree" button. You may exit the survey at any time.

Thank you for considering participation in this study.

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