Published in final edited form as:

Adv Eat Disord. 2014 January 1; 2(2): 204–208. doi:10.1080/21662630.2013.869391.

Understanding Eating Disorders among Latinas

Fary M. Cachelin, Ph.D., Virginia Gil-Rivas, Ph.D., and Alyssa Vela, B.A.

Department of Psychology, University of North Carolina Charlotte, United States

Abstract

This paper provides a brief summary of the literature on eating disorders (EDs) among Latinas in the U.S and presents data that illustrate symptomatology and associated psychopathology in this group. The current empirical evidence suggests similarities between Latinas and white European-American women in regards to risk factors, symptomatology, psychopathology, and prevalence of EDs. Despite these similarities, Latinas are less likely to report dieting, dietary restriction, and are more likely to be obese compared to white women. Although Latinas report distress associated with EDs, only a small proportion ever seek treatment. Several factors appear to contribute to their under-utilization of services including lack of knowledge, stigma, beliefs about seeking treatment, lack of health insurance, and lack of affordable and accessible treatment services. It is unclear whether the identified differences between white and Latina women are the result of cultural factors or are better explained by disparities in SES. Efforts to meet the treatment needs of Latinas in the U.S. should aim to increase awareness and education about EDs in this population and to address cultural beliefs and norms that may act as barriers to treatment utilization. Further, it is important to educate and train healthcare professionals to be aware that EDs may develop in or affect Latina patients, and to develop accessible, culturally-appropriate and cost-effective evidence-based treatments that can be disseminated through partnerships with primary care providers and community organizations.

Keywords

barriers; eating disorder; Latinas; treatment

This “Global Postcard” describes eating disorders (EDs) in the Latina community in the United States. Latinos are the fastest growing and largest minority group in the United States. The Latino population is highly heterogeneous, and includes individuals from varied countries of origin, generational status, and socioeconomic status (SES). We begin by presenting two case illustrations of Latina women with eating disorders from different backgrounds. Then, we briefly describe symptoms and associated pathology among Latinas

Address correspondence to: Fary M. Cachelin, Department of Psychology, University of North Carolina Charlotte, fcacheli@uncc.edu.

Notes on contributors

Fary M. Cachelin, Ph.D. is Chair and Professor of Psychology at the University of North Carolina at Charlotte. She has published extensively on eating disorders and associated problems in ethnically diverse communities, with a particular emphasis on Mexican American women.

Virginia Gil-Rivas, Ph.D. is Associate Professor of Psychology at the University of North Carolina at Charlotte where she serves as Director of the Health Psychology Doctoral Program. **Alyssa Vela** is a Master’s candidate in the Clinical Community Psychology Program at the University of North Carolina at Charlotte.

with EDs, present descriptive data on symptomatology and psychopathology for a community sample of Latinas with binge eating disorders, discuss barriers that hinder treatment seeking, make recommendations for future research and practice, and consider challenges posed by cultural and SES-related factors. For the duration of this paper, “Latinas” will refer to Latinas in the U.S.

Eating disorders in U.S. Latinas: What do they look like?

Case illustration #1

K.P. is a 20-year-old college student born in the United States to parents who emigrated from Mexico. She lives at home with her parents and describes having excellent social support from family and friends. She is a highly motivated student who works several jobs in addition to attending school. K.P. reports that her weight and shape are of little importance to her; however, she is very petite and has sought medical care for being underweight. Despite her size, she consumes large amounts of food during a typical binge. Her work schedule often causes her to go the entire day without eating, and at night she will then consume an entire day's worth of food in one sitting. For example, one night from 9:00 to 10:30 p.m., she consumed two hot pockets, five bowls of cereal, three cups of noodles, a small salad, a grilled chicken breast, and a snack-size bag of Doritos. She explains that since she is so hungry at the end of the day, once she begins eating she “just can't stop.” She describes a loss of control as: “Once I begin eating I feel I have to eat more and more.” Cereal, ice cream and chips are the trigger foods she most commonly associates with a binge and with feelings of being unable to stop eating. To avoid bingeing, K.P. will lock herself in her bedroom and avoid the first floor and kitchen area of her house after dinnertime. K.P. reports that she has an average of nine binge episodes during a typical month. She recognizes that her eating habits are unhealthy and could cause her long-term harm, but feels she is unable to control them. K.P. expresses that she is interested in making changes to her eating for her own health.

Case illustration #2

B.A. is a 33-year-old Mexican woman. She is a mother of four daughters from three fathers who no longer support her. She describes her life and childhood as having been very difficult. Since moving to the United States, B.A. and her daughters have resided with her brother and his family who help to support her. She has an eighth-grade education and works part-time and only as needed. Money is a major concern and her eating patterns recently were affected by a stomach illness that went untreated for several weeks because of lack of health insurance. B.A. is very overweight and hopes to gain control over her eating and her size. She is highly concerned with her weight and her shape and has constant fear of weight gain and feelings of “fatness”. She describes being easily triggered to binge when her daughters are eating unhealthy yet appealing foods. She also frequently binges after her children go to sleep. B.A. describes a typical binge as being an entire bag of groceries; she rarely eats breakfast and eats late most nights. B.A. reports that she binged on 20 of the 28 days prior to her interview, and twice on most of those days. For example, one night from 11:00 to 11:30 p.m., she consumed two large portions of rice, two large portions of beans, four pieces of meat, and 15 tortillas. B.A. expresses a desire to change her eating patterns for

both her appearance, since she is a single woman, and her health. She is concerned that her health will interfere with her ability to care for her daughters.

As these case illustrations demonstrate, eating disorders do exist among Latinas. Although no true epidemiological studies have been conducted, existing data indicate that rates of occurrence are similar to those reported for the general population of U.S. females (Granillo, Jones-Rodriguez, & Carvajal, 2005). Lifetime prevalence estimates for bulimia (BN) and binge eating disorder (BED) among Latinas range from 1.9% to 2.0% and from 2.3% to 2.7%, respectively (Marques et al., 2010). Symptomatology and associated psychopathology are similar to those of European-American white women. As with white women, Latinas with EDs are more likely than healthy controls to report histories of abuse, particularly sexual abuse (Cachelin, Schug, Juarez, & Monreal, 2005), and to report lifetime experiences of depression, anxiety, substance abuse, and other comorbid disorders (Cachelin et al., 2005). The available empirical evidence suggests that risk factors for development of an ED may be similar for the two groups.

Despite these similarities, group differences in presentation of dietary restriction or drive for thinness have been identified. Latinas with EDs are less likely to report histories of dieting or current dietary restriction compared to white women (Marques et al., 2010), and anorexia nervosa is rarely noted in studies with Latinas. Among Latinas, binge eating (in the presence or absence of compensatory behaviors) is commonly reported and typically accompanied by obesity and its associated health problems (e.g., Regan & Cachelin, 2006).

To date there has been little research comparing diagnostic groups or criteria within the Latina population. For the most part, it seems that available diagnostic categories are adequate for detecting clinically significant eating problems and can be used in research and practice with Latinas. Using these diagnostic categories, we present descriptive comparisons of ED symptomatology and psychological functioning between groups of Latinas with BED (defined as binge eating on average at least twice per week for six months), recurrent binge eating (RBE, defined as binge eating on average at least once per week for three months), and BN (defined as binge eating and inappropriate compensatory behaviors on average at least twice per week for three months). Participants ($N = 61$) were recruited from Latino communities in two large metropolitan areas in the United States. A well-established diagnostic exam was administered as an interview in English or Spanish to establish eating disorder criteria and commonly-employed measures of psychopathology were used to assess psychological functioning (Table 1).

The three diagnostic groups are similar in eating-related pathology, age of onset, and psychological functioning. It is interesting to note that in this sample the average age of onset for women with BN is slightly later than those for BED and RBE, which is the converse of what is generally reported for European-American women (for whom onset of BN typically occurs earlier than BED). Latinas in the BN group report higher frequencies, on average, of binge eating and higher levels of psychiatric distress than those with RBE or BED. The association of BN with higher levels of pathology is well-documented for white European-American women and may have affected our sample size for BN by serving as a barrier to participation. Average weight is somewhat lower for the BN group as compared to

the other two diagnostic groups, which is as expected given their regular use of compensatory behaviors.

Overall, mean scores on these measures for this Latina sample are comparable to those reported for both white and Latina samples of women with BED and BN in recent studies (e.g., Franko et al., 2012). These data indicate that recurrent binge eating in Latinas is associated with significant levels of distress and psychopathology. Therefore, the most current criteria proposed in the recent Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), which formally recognizes BED as an ED with a threshold criterion of binge eating at one time per week for three months, appears to be valid for accurately detecting (binge) eating disorders in U.S. Latina populations. Unfortunately, these disorders are for the most part under-detected and undertreated.

Why don't they seek treatment?

Findings from community-based research indicate that a very small percentage of Latinas seek treatment for EDs, despite reporting clinically significant distress due to their disorder. Those few who do seek professional help typically turn to primary care physicians who may address the accompanying obesity but often miss the opportunity to recognize and treat the underlying ED (Cachelin & Striegel-Moore, 2006). The main barriers to treatment seeking are similar to those that hinder mental health care utilization in general – feelings of shame, fear of stigma, a belief that one should be able to help oneself, inadequate insurance coverage or financial resources, lack of awareness that a formal disorder exists and that treatments are available, and lack of confidence in healthcare providers (Cachelin & Striegel-Moore, 2006). As would be expected, greater acculturation to U.S. mainstream society may increase likelihood of treatment seeking among Latinas, although among community-based samples the effect of acculturation on EDs and help seeking is mixed (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001). Ultimately factors related to SES or education may play a greater role in help-seeking behaviors among Latinas.

What is clear is that binge eating disorders, with the accompanying weight problems and obesity, pose serious health risks. At the same time, while disparities in access to health care have diminished for all other minority groups, they have increased among Latino communities (Agency for Healthcare Research and Quality, 2006). Therefore, the lack of evidence-based ED treatments that are accessible to this population is of particular concern.

Implications for theory, research, and practice

The empirical evidence suggests similarities in risk factors, symptomatology, and associated psychopathology between Latinas and white European-American women. Diagnostic DSM criteria seem to fit Latinas, particularly the new DSM-5 criteria for BED. Despite these similarities, some group differences in behavior (i.e., dieting), symptoms (e.g., types of binges and foods consumed, expression of “loss of control”), and help-seeking behaviors are apparent. Future research is needed to investigate culture-specific factors (e.g., roles, beliefs, acculturative stress) that might help explain these differences. Furthermore, research to date has focused on samples of Mexican Americans in the U.S. or on Hispanic groups of unspecified origin. We are not aware of any data documenting differences in EDs or risk for

development of EDs between Latina groups. Given the potential importance of cultural factors in identification and treatment, additional investigations that focus on specific groups, or that compare groups, of Latinas would be valuable.

Importantly, it is unclear if such identified differences between Latinas and European-American women are the result of cultural beliefs and norms or the result of SES-related factors (i.e., lack of knowledge, education level, income, or employment status). Food consumption and preparation are mechanisms used by ethnic minority groups in order to maintain a sense of identity and “belonging” (Gans, 2009). Among Latinos, women serve as the “keepers” of cultural values by selecting and preparing foods and organizing family activities. Although culture plays a role in food choice, those choices are also determined by SES and other factors (e.g., geography, food availability). Financial difficulties, time constraints, and the multiple demands typically placed on Latinas from low-SES backgrounds are associated with preference for easy-to-prepare and energy-dense foods (Kaufman & Karpati, 2007). Future studies would benefit from including women from different Latino groups and from diverse SES backgrounds to systematically assess, and potentially disentangle, the joint influence of these factors on symptoms and behaviors among women with EDs with the aim of better addressing the needs of this population.

Based on the available evidence, efforts to meet the treatment needs of Latinas in the U.S. should aim to increase awareness and education about EDs and to address cultural beliefs or norms that may act as barriers to treatment utilization. Further, Latinos in general often rely on primary care providers for their mental health needs. As such, educating and training healthcare professionals on how to identify EDs can contribute to increased rates of detection and treatment. Finally, it is important to develop accessible, culturally-acceptable and cost-effective evidence-based treatments for Latina and low-income women that can be disseminated through partnerships with primary healthcare clinics and community organizations.

Acknowledgments

Funding

This work was funded in part by a grant from the National Institute of Mental Health [#1SC1MH087975].

References

- Agency for Healthcare Research and Quality. National Healthcare Disparities Report. Author; Rockville, MD: 2006.
- Cachelin FM, Rebeck R, Veisel C, Striegel-Moore RH. Barriers to treatment for eating disorders among ethnically diverse women. *International Journal of Eating Disorders*. 2001; 30:269–278. [PubMed: 11746286]
- Cachelin FM, Schug RA, Juarez LC, Monreal TK. Sexual abuse and eating disorders in a community sample of Mexican American women. *Hispanic Journal of Behavioral Sciences*. 2005; 27:533–546. doi:10.1177/0739986305279022.
- Cachelin FM, Striegel-Moore RH. Help seeking and barriers to treatment in a community sample of Mexican American and European American women with eating disorders. *International Journal of Eating Disorders*. 2006; 39:154–161. doi:10.1002/eat.20213. [PubMed: 16252278]

- Franko DL, Thompson-Brenner H, Thompson DR, Boisseau CL, Davis A, Forbush KT, et al. Racial/ethnic differences in adults in randomized clinical trials of binge eating disorders. *Journal of Consulting and Clinical Psychology*. 2012; 80:186–195. doi:10.1037/a0026700. [PubMed: 22201327]
- Gans KM. Implications of qualitative research for nutrition education geared to selected Hispanic audiences. *Journal of Nutrition Education*. 2009; 31:331–338. doi: 10.1016/S0022-3182(99)70486-3.
- Granillo T, Jones-Rodriguez G, Carvajal SC. Prevalence of eating disorders in Latina adolescents: Associations with substance use and other correlates. *Journal of Adolescent Health*. 2005; 36:214–220. doi:10.1016/j.jadohealth.2004.01.015. [PubMed: 15737777]
- Kaufman L, Karpati A. Understanding the sociocultural roots of childhood obesity: Food practices among Latino families in Bushwick, Brooklyn. *Social Science & Medicine*. 2007; 64:2177–2188. Doi:10.1016/j.socsimed.2007.02.019. [PubMed: 17383060]
- Marques L, Alegria M, Becker AE, Chen C-N, Fang A, Chosak A, Diniz JB. Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in healthcare access for eating disorders. *International Journal of Eating Disorders*. 2010; 44:1–9. doi:10.1002/eat.20787.
- Regan PC, Cachelin FM. Binge eating and purging in a multi-ethnic community sample. *International Journal of Eating Disorders*. 2006; 39:523–526. doi:10.1002/eat. [PubMed: 16634050]

Table 1
Comparisons between Latina women with BED, BN, and RBE on Eating Disorder
Symptomatology and General Psychological Functioning

	BED (n = 21)		BN (n = 16)		RBE (n = 24)		F	p
	M	(SD)	M	(SD)	M	(SD)		
Age	27.5	(6.2)	26.2	(8.2)	28.5	(6.8)	0.47	.62
BMI	35.1	(9.0)	28.8	(5.7)	33.1	(8.0)	2.98	.06
Age of onset	17.3	(6.6)	20.9	(7.9)	17.4	(5.8)	1.70	.19
EDE objective binge episodes past month	17.7	(113)	22.7 ^a	(28.2)	11.4 ^b	(9.4)	2.21	.12
EDE purging episodes past month	n/a		13.3	(16.5)	n/a		---	---
EDEQ Restraint	1.8	(13)	2.6	(12)	1.8	(12)	1.80	.18
EDEQ Eating Concern	2.7	(1.7)	2.6	(14)	2.2	(17)	0.33	.72
EDEQ Weight Concern	3.8	(18)	4.0	(13)	3.3	(18)	0.57	.57
EDEQ Shape Concern	4.0	(18)	4.3	(13)	3.8	(17)	0.29	.75
Beck Depression Inventory	15.1	(12.4)	22.8	(16.0)	14.2	(9.9)	1.86	.17
Brief Symptom Inventory	15.0 ^b	(14.2)	27.0 ^a	(20.3)	15.8 ^b	(115)	2.58	.09
Rosenberg Self Esteem	29.5	(6.4)	27.8	(6.5)	27.5	(5.2)	0.50	.61

Note. BED = Binge Eating Disorder; BN = Bulimia Nervosa; RBE = Recurrent Binge Eating;

EDE = Eating Disorder Examination; EDEQ = Eating Disorder Examination Questionnaire. Different superscripts indicate significant between-group differences at $p < .05$.