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La Ropa Sucia No Solo Se Lava En Casa: Let's Talk About Disordered Eating and Eating Disorders in the Latine Community

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Executive Summary

- In the United States, at least 28.8 million Americans will have an eating disorder in their lifetime, but less than 20% ever receive treatment.
- Latines are significantly less likely than White people to receive a recommendation or referral for further eating disorder care.
- Only 41% of Latinas are accurately diagnosed with an eating disorder.
- Binge eating disorder is the most common eating disorder within the Latine community. Binge eating is not included in the list of diagnoses covered by some insurance companies.

Background

Disordered eating is described as having an unhealthy behavior revolving around food and body.¹ Major causes of disordered eating include a want for weight loss and health promotion.² These behaviors are harmful, as they may lead to health complications, and are unfortunately common. The behaviors include participating in fad diets, cleanses, skipping meals, supplement misuse, and

heightened focus on appearance.³ Disordered eating has the potential to progress into an eating disorder. In the United States, an estimated 28.8 million Americans will have an eating disorder in their lifetime.⁴ Eating disorders can affect anyone regardless of age, gender, race, religion, ethnicity, sexual orientation, body shape, and weight.⁵ Untreated eating disorders can result in decreased heart function, cause gastrointestinal problems, brain damage, and death.⁶ Eating disorder research is allocated about \$21 million per year, \$0.73 per person affected.⁷ This is little federal funding for research compared to other mental health conditions.⁸

Body, Shape, and Weight

The idea that society has to look a certain way plays a role in the development of disordered eating and eating disorders. Diet culture and fatphobia have led people to strive for a specific body image and/or feel bad about their bodies. Diet culture is a system of belief that “worships thinness and equates it to health and moral virtue,” promotes weight loss as a way to achieve higher status,

“demonizes certain ways of eating while elevating others,” and oppresses people whose bodies don’t align with the supposed picture of “health.”⁹

Fatphobia, or anti-fat, is the bias, both implicit and explicit, of fat individuals¹⁰ “that is rooted in a sense of blame and presumes moral failing.” It is intrinsically linked to systems of oppression that include: anti-blackness, racism, classism, misogyny, etc. Fatphobia contributes to inadequate healthcare due to assumptions that one cannot be healthy due to being fat and weight-related structural barriers.¹¹

Race and Ethnicity

Although it is greatly stereotyped that eating disorders are more prevalent within the non-Hispanic White population, eating disorders are seen across all ethnic non-dominant groups.¹² Studies conclude comparable or higher prevalence of eating disorders within ethnic groups compared to non-Hispanic White people. Latines and African Americans have significantly higher lifetime prevalence estimates of bulimia nervosa (2.03% and 1.31%)

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compared to non-Latine White people (0.51%).¹³ There is also a significantly higher lifetime prevalence for "any binge eating" for Latines (5.6%), African Americans (4.83%), and Asians (4.74%) compared to non-Latine White people (2.53%).¹⁴ Eating disorders are also high among adolescents of ethnic non-dominant groups. Hispanic adolescents are significantly more likely to suffer from bulimia compared to non-Hispanics, and Black adolescents are more likely to exhibit bulimic behavior compared to White adolescents.¹⁵ Anorexia Nervosa is seen to have higher lifelong prevalence within non-Hispanic White people in some studies and no significant differences in others.¹⁶

Across the diverse populations, racism, trauma, poverty, and the thin ideal are factors that influence eating disorders.¹⁷ Although fat bodies are generally celebrated within the Latine community, acculturation to the United States and cultural pressure to pursue thinness lead Latines to do what it takes to achieve just that.¹⁸ Studies show that those with a stronger cultural ethnic identity, compared to those who acculturate to Western standards, have a lower risk of body dissatisfaction and engaging in eating disorder behaviors.¹⁹

Gender

Disordered eating and eating disorders are not just girls' or women's issues. Although common in women, researchers and clinicians are seeing a growing number of men and non-binary individuals who are seeking help for their

eating disorders.²⁰ Unfortunately due to preconceptions of who is affected by eating disorders, it is not clear if eating disorders are increasing in these populations or if more are being diagnosed or seeking treatment.²¹

Transgender and gender nonconforming individuals are at minimum four times more likely than cisgender individuals to struggle with an eating disorder.²² Within this population, "eating disorders and struggles with body image are often a symptom of the trauma associated with living in a cissexist, patriarchal, and queer antagonistic society rooted in the gender binary."²³ Societal ideals of what women and men are "supposed" to look like and under representation of nonbinary and trans individuals can impact how one perceives their own body.²⁴ Although gender and body dysmorphia vary from person to person, both impact how one perceives themselves and this can give rise to disordered eating and eating disorders.²⁵

Men and boys also experience body image issues, seeking the "ideal" lean and muscular body.²⁶ However, the space to discuss insecurities or vulnerabilities is not as common for men.²⁷ This can be attributed to masculinity and how we define it.²⁸ Those who identify as men are told by current society that it is unsafe to share, especially about body insecurity, in fear of ridicule or judgment.²⁹ Men who strive for the ideal body may partake in excessive exercise and the use of performance-enhancing substances.³⁰

Diagnosis & Treatment

Unfortunately, out of the estimated 30 million individuals in the United States who are diagnosed, less than 20% ever receive treatment.³¹ Low access to care is due to "insurmountable financial and insurance barriers, in addition to pervasive systemic oppression and bias."³² Levels of care for eating disorder treatment include: inpatient, residential, partial hospitalization program or day treatment, intensive outpatient, outpatient, intensive family treatment, and family-based therapy.³³ Healthcare coverage depends on the type of treatment and insurance, with intensive family treatment and family-based treatment rarely covered.³⁴

The coverage of eating disorder treatment is limited, especially for those with Medicare and Medicaid, because of the way these programs are designed.³⁵ "The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that exists to require group health plans and health insurance payors to provide mental health or substance use disorder benefits," where these benefits are "are required to have equal benefit coverage of mental health diagnoses as medical diagnoses."³⁶ Since medical issues are treated through inpatient or outpatient, the MHPAEA limits treatment to these options; and excludes residential, most partial hospitalization programs, and most intensive outpatient programs for eating disorders.³⁷ Additionally, "medical necessity" is an old medical requirement for higher levels of care that some insurance companies are still

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following.³⁸ This eliminates coverage for eating disorders and disordered eating that include binge eating and other specified eating disorders, which are the forms that the majority of people are seeking treatment for.³⁹

Problem Analysis

The Lack of Research and Diagnosis

Eating disorder and disordered eating research among and including marginalized communities and identities are limited.⁴⁰ This is due to most treatment being primarily researched on and designed for white adolescent cisgender girls with Anorexia Nervosa.⁴¹ This is most likely due to eating disorders being stereotyped as a White cisgender women's issue, Anorexia Nervosa being the most prevalent eating disorder in this population, and the field mainly composed of White cisgender women.⁴² The lack of diverse research hinders the ability to generalize study results and "prevents some populations from experiencing the benefits of research innovations."⁴³ However, within the limited research, disordered eating and eating disorders are seen within the Latine community. Depending on the eating disorder, Latines and Hispanics have equivalent or more rates of eating disorders than non-Hispanic white people.⁴⁴ For example, Latino men have a significantly higher lifetime prevalence of bulimia nervosa compared to non-Latino White men.⁴⁵ Also, "any binge eating" is high for Latines compared to non-Latine White people.⁴⁶ Although prevalent in the Latine community, diagnosis and treat-

ment for eating disorders is an issue. Due to primary research, assessments, screening tools and treatment focused on and developed and validated for cisgender White women and girls, Latines are at risk of experiencing underidentification of symptoms.⁴⁷ In practice, most available English-language assessments focus on White women's ideals on appearance and weight loss, meanwhile, Latine's "may restrict their food intake for the purpose of attaining control."⁴⁸ Therefore it is important to develop diverse screening tools and assessments to better detect eating disorders and disordered eating.

A study conducted in 2003 observed that Latine, and Native American, participants were significantly less likely than the White participants to receive a recommendation or referral for further care, mainly due to clinician bias and not being asked about eating disorder symptoms by their healthcare provider.⁴⁹ Therefore, many Latines are often underdiagnosed and overlooked. For example, a 2006 study concluded that only 41% of Latinas are accurately diagnosed with an eating disorder.⁵⁰

Recommending Weight Loss Instead of Eating Disorder Treatment

When one actually seeks care for their disordered eating or eating disorder, the physician addresses the "obesity" and overlooks the signs of an eating disorder.⁵¹ According to the CDC, about 44.8% of Latine adults live with

"obesity" and is the second highest group compared to other ethnic and racial non-dominant groups.⁵² Since "obesity" is associated as a risk factor for chronic diseases, weight loss is often recommended, which can also bring about an eating disorder or disordered eating. For example, weight loss is recommended for those with adult onset type 2 diabetes mellitus (T2DM), in which Latines have one of the highest rates at 17%.⁵³ However, there is an unstable association between Body Mass Index (BMI)⁵⁴ and T2DM. For the Latine population, the odds of T2DM with every unit increase in BMI were lower compared to White people.⁵⁵

In addition, binge eating disorder is associated with "obesity" and T2DM (along with other medical conditions).⁵⁶ Therefore, focusing solely on the weight of a person can actually lead to worse health outcomes and contribute to weight stigma, especially when the lack of quality of care is common for those who are fat.⁵⁷

Under-Utilization of Services

The lack of research and diagnosis plays a significant role in the lack of treatment within the Latine community—however, this population also under-utilizes services.⁵⁸ Factors that contribute to under-utilizations include lack of knowledge, fear of shame and stigma, a belief that one should be able to help oneself, lack of healthcare coverage, and lack of affordable and accessible services.⁵⁹

Within the Latine community, talking about your struggles, especially about mental health and related eating disorder struggles, is something seen as shameful. A phrase many may hear is, “la ropa sucia se lava en casa” (similar to the phrase “don’t air your dirty laundry in public”). This encompasses the stigma that is placed within the community regarding seeking help.⁶⁰

Then there is the population of Latines who want to seek help, but simply cannot afford it. As of 2021, 19% of Hispanics are uninsured (the second highest uninsured group), 33% are insured through Medicaid or other public insurance, and 48% are insured by their employer or other private insurance.⁶¹ This creates a barrier to receiving appropriate medical care in general, with a bigger barrier for those who are documented and undocumented immigrants (before being able to enroll in Medicaid, many immigrants have to wait 5 years after obtaining lawful status and undocumented immigrants are not eligible to enroll in Medicaid and not permitted to purchase coverage through the marketplaces).⁶² Therefore, Latines may not seek eating disorder treatments due to the lack of health benefits and coverage for sessions.⁶³ For example, binge eating disorder is the most common eating disorder within this population, which is not included in the list of diagnoses covered by some insurance companies.⁶⁴

The Need for Diverse Providers

There are about 62.6 million Hispanics living in the United States (as of 2021) with 19.8 million Latines born outside of the

country and 1.9 million born in Puerto Rico (as of 2019).⁶⁵ In the 2015 U.S. Transgender Survey, 35% of Latines identified as non-binary, 31% as Transgender women and 33% as Transgender men.⁶⁶ There is a need for cultural care for this population— however, there is a lack of BIPOC (Black, Indigenous and People of Color) and LGBTQ+ eating disorder providers.⁶⁷ Project HEAL estimates that about 150 or 5% of providers are BIPOC or LGTBQ+.⁶⁸ There is a need for diverse providers due to the “lack of clinician awareness of cultural differences in nutrition and food choices” and a need for bilingual providers.⁶⁹

Treatment must be adapted to be culture-specific and competent.⁷⁰ In the United States, there have only been two main cultural adaptations for evidence-based treatment, which was conducted in Latinas with binge-eating type eating disorder. Cultural adaptation to treatment can be significant in education, prevention, treatment, and retention.⁷¹

Conclusion

In order to create equitable care for the Latine community, the disparities in treatment access, lack of research, and lack of culturally competent care must be addressed. Latines, as well as other groups, have their own unique culture and needs that should be respected. The United States is one step closer to achieving this. On December 23, 2022, the 117th Congress passed the Anna Westin Legacy Act, and funding for eating disorders research and training, within the end-of-year package (signed by President Biden on December 29, 2022).⁷² The Anna Westin Legacy Act provides continued training for primary health

care professionals on eating disorders screening, brief intervention, and referral to treatment.⁷³ The legislation will help providers better screen and refer children, BIPOC, LGBTQ+, men, and other at-risk communities.⁷⁴

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