



Published in final edited form as:

J Lat Psychol. 2013 May ; 1(2): 112–131. doi:10.1037/a0032318.

Exploring barriers and facilitators in eating disorders treatment among Latinas in the United States

Mae Lynn Reyes-Rodríguez, Ph.D.¹, Juanita Ramírez, BA², Kendra Davis, BA³, Keshia Patrice, BA⁴, and Cynthia M. Bulik, Ph.D.^{1,5}

¹Department of Psychiatry, University of North Carolina, Chapel Hill, NC

²Department of Psychology, University of North Carolina, Chapel Hill, NC

³Department of Psychology, University of Georgia, Athens, GA

⁴Department of Psychology, California State University, Sacramento, CA

⁵Department of Nutrition, University of North Carolina, Chapel Hill, NC

Abstract

The purpose of this study was to explore facilitators and barriers that may contribute to, or prevent, the engagement and retention of Latinos in eating disorders (EDs) treatment.

Objective—The main objective of this investigation was to explore more fully the facilitators and barriers that may contribute to or prevent the engagement and retention of Latinos/as in EDs treatment.

Methods—A qualitative design based on grounded theory was used to guide in-depth interviews with 5 Latinas (mean age 31.2 years) with history of EDs and with 5 Latino mental health providers (mean age 36.4 years).

Results—Six main themes were found in the discussion with patients and mental health providers: immigration stress, treatment experience in the U.S., facilitators of help seeking, barriers to help seeking, treatment needs, and facilitators of treatment retention. For patients, lack of information about EDs and lack of bilingual treatment were identified as practical barriers. Other emotional factors such as stigma, fear of not being understood, family privacy and not being ready to change were identified as barriers to seeking help. Among facilitator factors that encouraged patients to seek help, the most salient were the perception of the severity of the ED and emotional distress. For treatment retention, family support was a key element among patients. For providers, offering short-term treatment and directive treatment were seen as relevant factors for treatment retention in Latinos.

Conclusions—A culturally sensitive intervention model for Latinas with EDs in the U.S. is discussed addressing four levels: patient; family; providers; and system.

Keywords

treatment barriers; Latinas; eating disorders; treatment facilitators; treatment retention

The lifetime prevalence of anorexia nervosa (AN) among Latinos is .08% in women and .03% in men, of bulimia nervosa is (BN) 1.9% in women and 1.3% in men, and of binge eating disorder (BED) is 2.3% in women and 1.6% in men (Alegria, Woo, Cao, Torres,

Meng et al., 2007). The medical consequences of these disorders range from minor to severe and in some cases can lead to death (Mitchell, Pomeroy, & Adson, 1997). Despite a common misconception that women of minority groups do not typically develop eating disorders (EDs), data from college and community samples indicate that EDs are equally prevalent in minority groups as in the non-Latino White population (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Franko, Becker, Thomas, & Herzog, 2007). Furthermore, although the prevalence of AN and BN in Latinos/as and non-Latino Whites is similar, some studies have shown that the prevalence of BED is higher among Latinos/as (Alegria et al., 2007; Marques, Alegria, Becker, Chen, Fang et al., 2011). Some specific factors such as consumption of fat (Wilson, O'Connor, Kaplan, Bode, Mama et al., 2012), overweight, and obesity (Sanchez-Johnsen, Hogan, Wilkens, Fitzgibbon, 2008) are associated with increasing risk for developing binge eating or bulimic symptoms in this population. In Latino males, elevated rates of EDs are associated with homosexuality (Carlat, Camargo, & Herzog, 1997; Hospers, 2005), athletes (Petrie, Greenleaf, Reel, & Carter, 2008) and trauma history (Olivardia, Pope, Mangweth, & Hudson, 1995). However, high frequencies of disordered eating behaviors have also been documented in male Latino college populations (Reyes-Rodríguez, Sala, Von Holle, Unikel, Bulik et al., 2011).

Health disparities among Latinos are well documented (Cabassa, Zayas, & Hansen, 2006) and they are associated with cultural specific factors, such as a mental health stigma (Nadeem, Lange, Edge, Fongwa, Belin et al., 2007), ethnic identity, language preference and barriers, economics, and treatment seeking-patterns including avoidance of specialized services (Alegria, Canino, Rios, Vera, Calderon, Rusch, Ortega, 2002; Keyes, Martins, Hatzenbuehler, Blanco, Bates et al., 2011; Snowden & Yamada, 2005). For Latinos/as with limited English proficiency, practitioners who must use an interpreter constitute another challenge (Bourhis, Roth, & MacQueen, 1989; Dodd, 1984; Seijo, 1991). Some studies indicate that few interpreters provide accurate translations for practitioners, and even with accurate interpretations, practitioners may still fail to fully understand the nature and extent of presenting symptoms (Elderkin-Thompson, Silver, & Waitzkin, 2001). In particular, limited access to health care can be a barrier to the utilization of services for EDs (Snowden & Yamada, 2005). Additionally, Latinos/as with a history of EDs are less likely to utilize mental health services (Marques et al., 2011) and to be referred for further evaluation (Becker, Franko, Speck, & Herzog, 2003; Franko et al., 2007) in comparison to non-Latino Whites.

The development of culturally sensitive intervention models is a key component to reducing health disparities in the Latino population (Reyes-Rodríguez & Bulik, 2010). The recognition of cultural values is important for providing adequate treatment for EDs in the Latino population (Kempa & Thomas, 2000). Specific protocols and guidelines that integrate culture and context in evidence-based care could contribute to engagement in treatment and ultimately enhance treatment outcomes (Miranda, Bernal, Lau, Kohn, Hwang et al., 2005). In the case of Latinos/as, it is necessary to develop models that would inform investigators about the specific procedures involved in making and documenting adaptations to treatments. In part, the challenge is to identify key cultural and contextual factors that can be adapted within a given treatment (Reyes-Rodríguez & Bulik, 2010). In addition, it is important to specify the ways in which the key elements that are postulated to be essential for positive treatment outcomes are transformed and/or sustained during the treatment process (Bernal & Reyes-Rodríguez, 2008). The incorporation of culture and context into interventions leads to the development of multicultural guidelines for clinical practice, research, and education. For example in the Latino population it is important to consider the role of family, migration, language, and specific cultural values (e.g., *familismo*, *personalismo*, *fatalismo*, ethnic identity, dependence, independence), which differ

depending on the length of time an individual has spent in the U.S., and on the migration experience and the relationship to the dominant culture (Bernal & Reyes-Rodríguez, 2008).

Considering the prevalence of EDs in Latinos/as, the current underutilization of mental health services and the barriers to treatment access, it is crucial to identify specific factors that could enhance service utilization for ED treatment in the Latino population. The main objective of this investigation was to explore more fully the facilitators and barriers that may contribute to or prevent the engagement and retention of Latinos/as in EDs treatment.

Methods

Design

Grounded theory approach (Strauss, 1990) was used to guide in-depth interviews with Latina patients with a history of EDs and with Latino mental health providers. Grounded theory is defined by Glaser and Strauss (1967) as a method to generate a theory from data obtained via systematic research. This specific qualitative method promotes the discovery of rich description of patterns of behavior obtained from unique experiences with the phenomenon under discussion (Glaser, 1996). In grounded theory, the researcher begins with a broad research question, and through a process of discovery reliant on individual and group dialogue, the researchers perceive the questions that need to be asked. Consequently, during the interview process, the questions are constantly evolving. As a dynamic process, in grounded theory, the researcher is interacting constantly with the data, which guide the emerging theory that is tested against data that are systematically collected. This specific approach allows for the interconnection of theoretical systematic coding procedures and conceptualization in order to develop hypotheses that will be integrated into a theory (Mertens, 2005).

Participants

Five Latina women with a history of EDs and five female mental health care providers, who serve Latinos/as, participated in a semi-structured in-depth interview. To be considered for the study, Latina women had to be 18 years or older and either with a history of or current eating disorders (e.g., AN, BN, or BED) or sub-threshold symptoms. Inclusion criteria were explored through a brief telephone screen conducted by the first author. Patients were recruited through advertisements and outreach in diverse Latino community centers, mental health clinics, and by referrals from health providers. Two patients were referred by other mental health professionals due to their BN diagnosis. At the time of the study, one patient was enrolled in treatment for BED at the university hospital facility and was referred by her therapist for participation. The other two participants responded to recruitment materials posted in the community.

Mental health providers were included based on their experience working with Latinos. An invitation letter was sent via email to all clinicians employed by a non-profit mental health clinic devoted to serving the Latino population. Five of the nine mental health providers responded to the invitation letter.

The age of the patients ranged from 26 to 38 with a mean age of 31.2 years. Four Latina patients were immigrants from Latin America and they had lived in the U.S. between 3 to 33 years. Two Latinas were undocumented and one was born in the U.S. to first generation immigrants. In terms of the EDs history, three patients presented with a previous diagnosis of BN, one with BED, and another with binge-eating behavior. Two patients were enrolled in treatment for their ED at the time of the study, two were referred for treatment, and one was recovered. The age of the mental health care providers ranged from 25 to 46 with a mean age of 36.4 years. All of the mental health care providers had either a masters or

doctoral level degree in social work or counseling with a mean of 7 years of experience working with the Latino population. Due to the lack of specialized services for Spanish speakers with EDs in the area, we included general mental health providers in the study to explore their experience with Latinos/as with EDs and their willingness to receive training in evidence-based treatment for EDs. Areas of expertise of the providers were family conflict, trauma, and substance abuse. The race/ethnicity of providers were Caucasians (n=4) and Latina (n=1). All were bilingual and self-identified as bicultural.

Data Collection

The study was approved by the local Institutional Review Board (IRB) and informed consent forms were completed for all participants. The data were collected between October 2010 and April 2011. All interviews were conducted in Spanish and audiotaped for the purpose of qualitative analysis; however, identifying information was not collected. Most of the interviews (n=9) were conducted face to face at the community mental health clinic or at university facilities. One interview was conducted by phone due to the distance of the participant's home from the research study facilities. Patient interviews lasted between 45–62 minutes and provider interviews lasted between 28–33 minutes. Latina patients received an incentive of \$30. Mental health care providers were not compensated monetarily.

Measures

In-depth interviews were conducted by the first author and a trained research assistant. The in-depth interview guideline was developed based on a previous focus group with Latinos/as in Central North Carolina to explore the availability and accessibility of mental health services in the Latino community and a literature review on relevant topics. Based on the information gathered from the focus group, as well as our review of the literature, we developed guideline questions to cover relevant topics in the EDs field, but also to respond to the needs of Latinos/as in the mental health services field. The questions were used to guide the interview; however, the interviewers were trained to probe beyond the guide questions. The interviews included open-ended questions and for patients, questions fell into five main topic areas: general needs, facilitators and barriers to ED treatment, familial and other sources of support, previous experiences with treatment, and treatment expectations. For the mental health care providers, questions also included five main topics: facilitators of engagement and retention, family dynamics, expectations of treatment, the delivery of evidence-based treatment, and the treatment of EDs (see Table 1). To establish the credibility of the obtained data, member checks were used. This strategy allowed the researcher to verify the information provided by responders. For example, during the entire interview the interviewers clarified information and at the end of each interview, all interviewees were given the opportunity to make any additional comments or talk about relevant topics that were not covered during the interview process.

Coding process and analysis

Coding—All interviews were transcribed verbatim by the research team and compared with the original recording by the PI to ensure the integrity of the transcriptions. The transcriptions were transported to NVivo 9 software for qualitative analysis (NVivo, March 2008). Three independent bilingual coders (i.e., first author, graduate student, undergraduate research assistant) conducted the analysis. Two coders were Latinas and one was a bilingual Caucasian who had extensive experience working with Latinos in Latin America.

Analysis—The qualitative analysis process is described below. First, two codebooks (patients & providers) were created based on the categories of the guideline questions. Second, open coding was conducted by the coders to identify preset categories or nodes

from transcripts and additional or emergent topics were added that were not included in the original guideline but were discussed by the participants. For example, specific barriers and facilitators to treatment were identified by patients and providers; however, questions about the source of barriers or facilitators were raised (e.g., patient, family, provider, system). The entire transcripts or protocols from all participants were used for the coding process. Sentences expressing an idea were considered the unit of analysis. Third, axial and selective coding was performed to identify patterns and connection within and between categories in order to find higher order categories. Fourth, interpretation and analysis of categories was conducted as a final step. As part of the analytical process, similarities and differences in response patterns were identified and a discussion was conducted in order to generate a conceptualization model. Based on participants' discussion, a culturally sensitive intervention model was proposed, integrating facilitators and addressing barriers in order to enhance the engagement and retention in treatment for Latinas with EDs in the U.S. Comparative methods were implemented during the entire data analysis (Mertens, 2005). A discussion process and consensus coding was developed by the three coders based on the topics with highest frequencies. The frequency of each category was determined by the number of times the specific theme was raised throughout the discussion.

In order to avoid any interview or coder bias the following steps were taken. First, a pre-planned interview guideline was developed based on a literature review and previous experience with the topic. Second, the active interaction process was used between the interviewer and respondents to verify and clarify information provided by interviewees in order to collect the most accurate information. Third, at the end of each interview, all interviewees were given the opportunity to include additional comments or relevant topics that were not covered during the interview process. Fourth, the use of verbatim transcription from all interviews allowed for qualitative analysis by three independent coders.

Results

Six main themes were identified by coders by reviewing transcribed interviews from the discussions with the patients and mental health providers: immigration stress, treatment experience in the U.S., facilitators of help seeking, barriers to help seeking, treatment needs, and facilitators of treatment retention (see Table 2). Additional excerpts from in-depth interviews are included in Table 3.

Immigration Stress

During the initial questions about their immigration experience, most of the Latina patients (n=4) reported that immigration was a source of distress, especially due to separation from family members. This separation contributed to a sense of loneliness, a lack of support and, for some, economic dependence on others (e.g., partner). The patient who was born in the U.S. did not experience the immigration process. For those patients who were economically independent in their country (n=3), to have to depend on others financially due to the difficulty finding a job was considered stressful. For example a patient mentioned “...*en este país es muy, muy difícil encontrar un empleo...yo siempre he sido independiente por mi misma, entonces, depender de mi esposo se me hizo difícil...no tener dinero y pedirle a él, esas son cosas muy difíciles para mí*” [Patient-01]. [In this country it's very, very difficult to find a job...I've always been independent, so depending on my husband was very hard for me...not having money and asking him for it, these are very difficult things for me].

The immigration stress experienced by patients was also perceived by some providers as an area that contributes to a general lack of support in treatment. One provider explained, “*Desafortunadamente la gente que a veces vienen con más problemas son los que no tienen apoyo familiar, no tienen familia aquí*” [Provider-05]. [Unfortunately the people who

sometimes come in with more problems are the ones who don't have family support, who don't have family here].

Treatment Experience in the U.S

The patients' previous treatment experience in the U.S. was explored and the main issues discussed by patients included a lack of information about EDs and a lack of bilingual treatment. For those patients with a history of EDs before arriving in the U.S. (n=2), the lack of information about EDs contributed to a perception that these disorders are uncommon in the U.S. Latina population. One patient explained, "...*aquí es muy difícil porque casi no sé si hay personas que lo padezcan...aquí es muy difícil encontrar ayuda... yo lo sentí...muy difícil como que, en este país no padece nadie de esa enfermedad*" [Patient-01]. [...here it's very hard because I almost don't know if there are people that seem to have it..., here it's very hard to find help...I felt...it's so hard because in this country there doesn't seem to be anyone with this disorder].

Moreover, physician's failure to recognize ED symptoms accentuated mental health stigma and the misconception that EDs do not occur in Latinas. For example, although one patient discussed her bulimia symptoms with different health providers, her symptoms were never identified as an ED and subsequently appropriate referrals were not made. She reported that: "*El doctor me veía la garganta y me hacía comentarios como –wow, your throat is really raw-y le dije 'I think I'm bulimic-y no más voltio y me vio y no me contestó nada'*" [Patient-06]. [The doctor saw my throat and commented, "Wow, your throat is really raw." And I told him, "I think I'm bulimic" and turned around and he looked at me and didn't respond at all].

One of the patients described a situation in which she was without treatment for approximately seven months after confiding in her therapist about her ED symptoms. Thus, all treatment ceased until specialized treatment for her EDs was found. This experience intensified her feelings of stigma associated with ED symptoms and strengthened her notion that EDs are not appropriate to discuss. "*Entonces, en mi estaba como, ¿Por qué dije eso? No hubiera tocado ese tema... me hubieran ayudado con la depresión*" [Patient-01]. [So then, I was like, why did I say that? If I hadn't brought up that topic, they would have helped with the depression].

Consistently it was mentioned that group support from other Latinas suffering from EDs is needed. This type of support would convey the message that other Latinas in the U.S. suffer from these disorders and help to deconstruct some of the associated stigma. All patients stressed the necessity of bilingual services, especially for mental health care. Patients with previous experience using an interpreter in health/mental care reported discomfort during treatment sessions due to the lack of privacy and frequent misunderstanding regarding symptoms among themselves, interpreters, and clinicians. Also, one patient reported an experience in which an interpreter added their understanding of a situation and personal advice to the information exchanged between the patient and her doctor. "...*aparte la interprete...me decía lo que me decía ella [terapeuta] pero aparte me decía lo que ella [interprete] pensaba de lo que yo le decía entonces era...difícil... no solamente tener que contarles mis cosas al psicólogo...pero con un intérprete también, que no tenía nada que ver*" [Patient-08]. [The interpreter would tell me what she [the therapist] was saying to me but would also tell me what she [the interpreter] thought about what I was saying so it was... difficult...not only having to tell my issues to the psychologist...but also with an interpreter as well, that had nothing to do with it.].

Facilitators of Help Seeking

Among facilitators or precipitating factors that encouraged patients to seek help, the most salient were the perception of ED severity and the experience of emotional distress. “*Cuando una vez que vomito sangre, fue cuando me asusté, o sea, ¿qué esta pasando en mí?*” [Patient-01]. [When I vomited blood one time that was when I got frightened. I thought, what’s happening to me?]. The same patient mentioned that along with the severity of the condition, having a family member or friend encouraging them to seek help in a concrete way was essential to treatment engagement. “*...a veces tirada en la cama, entonces me ayudaron a buscar ayuda*” [...at times I was unable to get out of bed, so they helped me look for help]. In another example, one patient mentioned that in her situation it was not the lack of information that prevented her from seeking help, but rather the realization that she could not recover on her own. “*No es falta de información. Era falta de... decir, “OK... (Nombre del participante)” que no lo puedes hacer, yo sola.*” [Patient-02]. [It wasn’t lack of information. It was lack of saying, “OK (participant name)” you cannot do it”, by myself].

For mental health providers, flexibility concerning business hours and payment sliding scales were important facilitators for the Latino population because many individuals work double shifts and lack health insurance. For example, “*...lo más distinto [factores] pienso que son el horario y estar flexibles con [los pacientes] y la transportación y por las mujeres el cuidado de los niños*” [Provider-10]. J. [...the most important thing is scheduling and flexibility with patients, transportation and, for women, childcare].

Barriers to Help Seeking

Patients discussed barriers to help seeking such as: the stigma of having an ED, the fear of not being understood, the inability to keep family issues private, and the feeling of not being ready to change. Greater stigma related to EDs was reported in comparison to other mental health conditions. One patient mentioned “*...a parte de que ya me tiraban la loca ... ese ‘stigma’ todavía queda en mí un poco... y creo que también es un poco, esa idea del elefante. Que las cosas no se les dice por su nombre...eso también es muy, bueno mi experiencia con mi familia y con la familia extendida...eso es muy latino. El tenerle miedo a... las enfermedades*” [Patient-06]. [Aside the fact that they considered me crazy...that stigma still exists in me a little... I think it’s also a bit, the idea of the elephant [in the room]. That you don’t call things by their name... well my experience with my family, and extended family is that’s very Latino. To be afraid of ... diseases]. In another example, some patients reported feeling more comfortable seeking mental health services for other emotional stressors (e.g., depression, anxiety) than revealing their ED symptoms. This stigma was heightened due to an additional fear of not being understood by mental/health providers and by family members.

Another factor that prevented Latinas from seeking help was the belief that family issues should be addressed inside the family nucleus. “*El latino es básicamente, es más privado... no les gusta, como compartir sus cosas con la gente metida. So, si tienen un problema es mejor que si, si es entre... la familia...una de mis hermanas...sufre de bulimia so, casi cuando ella estaba bien mala solo... mantuvimos simplemente entre todas mis hermanas. La mandamos a un tratamiento pero todos se, “kept the secret”, era un secreto*” [Patient-02]. [Latinos are basically, more private...they don’t like sharing their personal business with nosy people. So, if they have a problem it’s better that it’s among...the family...one of my sisters suffers from bulimia and when she was so bad...we just kept it between all of my sisters. We sent her to treatment but we all “kept the secret”, it was a secret].

Treatment Needs

Regarding treatment needs, patients reported three critical elements: the need for someone to talk to who can understand them, the need for not being judged, and the need for having a safe environment. For example, one patient mentioned: “*En mi caso es como buscar una persona que te entienda, que sepa entenderte, tu depresión o sin criticarte*” [Patient-01]. [In my case it’s like looking for a person who understands you, that knows how to understand you, your depression or without criticizing you]. Other patient described the same requirements: “*sentir apoyo*” [Patient-02]. [feeling supported]; “*Una persona que me entendiera*” [Patient-03]. [A person who understands me].

Facilitators of Treatment Retention

Patients and treatment providers frequently reported that having support from their family and friends during the treatment process was and can be an important part of treatment retention. “*Yo digo que si una persona tiene apoyo...esa persona va a ser más fácil triunfar, y hacer las cosas mejor. Cuando una persona no tiene apoyo “you’re not gonna succeed better”*” [Patient-02]. [I’d say that if a person has support, this person is going to have an easier time succeeding, and doing things better. When a person doesn’t have support, “you’re not going to do as well”]. Another patient mentioned: “*...recibir...apoyo de también otras personas. Como las amigas, las personas en donde trabajaba...me dieron más ayuda porque sentía el amor de ellos...me sentí bien porque este, el cariño de ellos, se preocuparon por mí. Todo eso...fue una cosa que también uno le ayuda a seguir adelante*” [Patient-01] [“receive...support from others also. Such as girlfriends, people where I worked...they gave me more help because I felt their love...I felt good because of their caring; they worried about me. All of this...was something that also helps to move forward”]. Notably, however, one patient remarked that some family members simply cannot be sources of support, especially if an abusive relationship has previously existed.

Treatment providers felt that short-term and directive treatment options are relevant factors to the retention of Latinos in treatment. Many Latinos come to treatment with the expectation of having only a few sessions—typically fewer than eight as discussed by providers. However, this expectation is not realistic in cases in which patients are dealing with many traumas and family conflict

Discussion

Limited access to treatment for EDs among Latinos has been documented (Marques et al., 2011); however, a full understanding of the factors that contribute to this disparity has not yet been made clear in the literature. In this study, Latinas with history of EDs and mental health care providers with experience working with the Latino population reported barriers and facilitators associated with mental health utilization in the U.S. Some of our findings concur with the general literature about mental health utilization in Latino population (Alegria, Cao, McGuire, Ojeda, Sribney, Woo, Takeuchi, 2006; Surgeon General Report, 2001), which underscore barriers such as lack of health insurance, lack of bilingual services, and differential help seeking pattern as contributors to limited treatment utilization. These barriers are associated predominantly with immigration status, access to care, poverty, and level of acculturation rather than with a specific general health or mental health condition. On the other hand, help seeking patterns in the Latino population (e.g., waiting until symptoms are severe), could be explained by cultural beliefs/values (e.g., a high need for privacy, pride in showing strength, a fear of being perceived to have a weak character) (Becker, Hadley Arrindell, Perloe, Fay, & Striegel-Moore, 2010) and fatalism. Fatalism is a cultural belief among Latinos in which life events are perceived as predetermined and, as a consequence nothing that can be done to change their course. Additionally these patterns

may also be engendering mistrust in the system (e.g., the health care system, the government) as a result of immigration status, or economic factors (Surgeon General Report, 2001; Woodward, Dwinell, & Arons, 1992).

Emotional or personal barriers also play a role in the treatment seeking behaviors of Latinas with EDs. In a study conducted by Cachelin and Striegel-Moore (2006), they identified “person factors” such as motivation, knowledge of resources, and stigma as treatment barriers. In the current study, we also found emotional/personal factors (e.g., fear of not being understood, not being ready to change), stigma, and lack of family support, as key elements that prevented Latinas with EDs from seeking treatment. These results highlight that providing practical facilitators (e.g., bilingual services, affordable care services) will not be enough to encourage Latinas with EDs to seek help. Another level of intervention should focus on a personal/emotional layer, specifically addressing the stigma, readiness to change, and the emotional stress associated with the sense of mistrust in others or in the system. One factor contributing to the stigma associated with EDs in this population is clinicians’ failure to recognize these disorders. As noted by some of the patients in the current study, this clinical bias perpetuated the misconception that EDs do not occur in Latinas, discouraged patients from seeking help, and increased the shame associated with having the condition.

The current study also identified a set of factors, described by both patients and treatment providers, which facilitated retention in treatment. Specifically, having the support of at least one family member or friend was highlighted by patients as a facilitator of treatment retention. Regarding treatment needs, a nonjudgmental therapist and having a safe environment (physically and emotionally) were relevant for the therapeutic process. For example, one participant described abandoning treatment after being asked by her therapist if she had confronted her family member about the reason he had sexually abused her. This participant described feeling that the therapist was justifying the abuse and therefore judging her. Providers interviewed in this study confirmed the necessity of developing and maintaining a trusting relationship between patients and providers for treatment retention, but also determined that Latino/a patients should be provided with short-term and goal oriented treatment. More specifically, providers felt that treatments that include specific instructions to help guide patients in solving their problems would contribute to treatment adherence and retention.

Based on the themes discussed by both patients and providers, we suggest a culturally sensitive intervention model for Latinas with EDs in the U.S. Figure 1 presents an intervention level model that can be considered in order to respond in a culturally sensitive way to the needs of Latinas with EDs. This intervention model is composed of four levels: patient, family, providers, and system. At the patient level it is necessary to address both the limited or lack of information and the misconception about EDs in the Latino culture by creating a psychoeducational program that provides bilingual information about EDs with factual information about the prevalence of this disorder in the Latino community and ways to treat it. The use of “fotonovelas,” a popular type of graphic novels, which are widely used among Latinas, is an avenue to educate this community about EDs. This approach has been used to create awareness about depression (Cabassa, Contreras, Aragon, Molina, & Baron, 2011) and to promote healthy eating habits (Sberna Hinojosa, Hinojosa, Nelson, Delgado, Witzack et al., 2011) in Latino communities. According to Cabassa et al., (2011) the use of a “fotonovela” was useful in combating mental health stigma, and in educating patients about the condition; however, some rooted misconceptions (e.g., fears about medication) were not successfully changed by this approach. Nevertheless, “fotonovelas” could be an initial step in developing a culturally sensitive approach for the education of Latinas about EDs, about medical and emotional consequences of EDs, and about resources available in the

community. This approach would also be helpful in educating families of patients by providing basic information about healthy ways to support a family member with EDs.

Intervening at the provider level would be important to create awareness among physicians about EDs in the Latino population, especially in primary care settings. Considering the barriers, in 2001 the World Health Organization (WHO) recommended the integration of mental health into the primary care setting (WHO, 2001). Currently, several practice guidelines recommend that screening of EDs should be considered in the routine care, especially with high-risk patients (American Academy of Pediatrics, 2003; Williams, Goodie, & Motsinger, 2008; Yager J, 2006). For example, primary care settings have been shown to be a potential avenue to early detection and a critical point of entry into the health system (Wang, Aguilar-Gaxiola, Alonso, Angermeyer, Borges et al., 2007) because patients with mental or emotional issues often initially present with a chief complaint of a physical nature (Williams, Goodie, & Motsinger, 2008). Approximately half of adults with EDs are diagnosed for the first time in a primary care setting (Walsh, Wheat, & Freund, 2000). Considering that Latinos regularly delay treatment until symptoms are more severe (Caballero, Sunday, & Halimi, 2003), tend to underutilize mental health services, and often terminate treatment prematurely (Alegria et al., 2006; Surgeon General Report, 2001), proper screening for EDs in primary care settings may be particularly helpful in the reduction of health disparities in mental health care.

Mental health providers, especially those who are dedicated to the Latino community, should be trained in recognizing the signs and symptoms of ED. As reported by some providers in this study, the lack of knowledge, and skills related to ED detection are factors that impede their assessment of Latina patients. Based on experiences of the first author, it seems that providing Latino mental health care providers with training and workshops about EDs in Latinos produces significant change in the recognition of these conditions. Furthermore providers became more willing to explore symptoms that sometimes are masked by depression or anxiety.

Within the system level, it is important to develop a comprehensive intervention approach that reflects the complexity of the Latino population, especially those who are first generation immigrants to the U.S. In particular these individuals often have no health insurance, have low income, and are unable to speak English fluently. A community-based approach or an integrative service (e.g., mental health and primary care services) could maximize the resources and the services that are already in place in the community.

Limitations should be considered when evaluating this study. First, due to the lack of mental health providers for the Latino community with expertise in EDs in Central North Carolina, we chose to include general mental health providers. The inclusion of providers with more experience working with EDs could provide a different perspective about barriers and facilitators in the specific treatment of EDs in the Latino population. Second, the inclusion of interviews with family members of Latinas with history of EDs could provide an additional important perspective on how these conditions have impacted family dynamics and enumerate the challenges they have encountered when seeking help for their loved one. For the current study it was not possible to recruit family members, in part because of the stigma associated with EDs in Latinas that contributes to keeping the condition a secret from family members.

Conclusions

This study underscores important factors that may enhance the engagement and retention of Latinas with EDs in treatment. A culturally sensitive multilevel approach is necessary to

address barriers related to immigration status and emotional or personal factors. Creating awareness about this condition in the Latino community and in health care providers is a first step in decreasing the stigma and clinician bias about EDs in Latinos/as. However, in order to manage the potential increase of referrals due to increased awareness and improved assessment, it is imperative to have culturally sensitive treatment models available for Latinos/as with EDs in the U.S. Providing a culturally sensitive treatment, especially for the less acculturated Latinos/as, along with the development of a trusting therapeutic relationship and a safe environment appear to be essential in encouraging the engagement and retention of Latinos/as in treatment.

Acknowledgments

This research has been supported by an NIMH grant (K23-MH087954) at the University of North Carolina at Chapel Hill. The NIMH had no further role in study design; in collection; analysis and interpretation of data; in the writing of the report; and in the decision to submit the paper for publication.

References

- Alegria M, Canino G, Rios R, Vera M, Calderon J, Rusch D, Ortega AN. Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatric Services*. 2002; 53:1547–1555. [PubMed: 12461214]
- Alegria M, Cao Z, McGuire TG, Ojeda VD, Sribney B, Woo M, Takeuchi D. Health insurance coverage for vulnerable populations: Contrasting Asian Americans and Latinos in the United States. *Inquiry*. 2006; 43:231–254. [PubMed: 17176967]
- Alegria M, Woo M, Cao Z, Torres M, Meng XL, Striegel-Moore R. Prevalence and correlates of eating disorders in Latinos in the United States. *International Journal of Eating Disorders*. 2007; 40(Suppl):S15–21. [PubMed: 17584870]
- American Academy of Pediatrics CoA. Identifying and treating eating disorders. *Pediatrics*. 2003; 111:204–211. [PubMed: 12509579]
- Becker AE, Franko DL, Speck A, Herzog DB. Ethnicity and differential access to care for eating disorder symptoms. *International Journal of Eating Disorders*. 2003; 33:205–212. [PubMed: 12616587]
- Becker AE, Hadley Arrindell A, Perloe A, Fay K, Striegel-Moore RH. A qualitative study of perceived social barriers to care for eating disorders: Perspectives from ethnically diverse health care consumers. *International Journal of Eating Disorders*. 2010; 43:633–647. [PubMed: 19806607]
- Bernal, G.; Reyes-Rodríguez, ML. Psychosocial treatments for depression with adult Latinos. In: Aguilar-Guaxiola, Sergio; Gullotta, Thomas P., editors. *Depression in Latinos: Assessment, Treatment and prevention*. New York: Springer-Verlag; 2008. p. 189-204.
- Bourhis RY, Roth S, MacQueen G. Communication in the hospital setting: A survey of medical and everyday language use amongst patients, nurses and doctors. *Social Science and Medicine*. 1989; 28:339–346. [PubMed: 2705006]
- Caballero AR, Sunday SR, Halmi KA. A comparison of cognitive and behavioral symptoms between Mexican and American eating disorder patients. *International Journal of Eating Disorders*. 2003; 34:136–141. [PubMed: 12772178]
- Cabassa LJ, Contreras S, Aragon R, Molina GB, Baron M. Focus group evaluation of “Secret Feelings”: A depression fotonovela for Latinos with limited English proficiency. *Health Promotion Practice*. 2011; 12:840–847. [PubMed: 21807951]
- Cabassa LJ, Zayas LH, Hansen MC. Latino adults’ access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health*. 2006; 33:316–330. [PubMed: 16598658]
- 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, 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. [PubMed: 16252278]
- Carlat DJ, Camargo CA Jr, Herzog DB. Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*. 1997; 154:1127–1132. [PubMed: 9247400]
- Dodd W. Do interpreters affect consultations? *Family Practice*. 1984; 1:42–47. [PubMed: 6530062]
- Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. *Social Science and Medicine*. 2001; 52:1343–1358. [PubMed: 11286360]
- Franko DL, Becker AE, Thomas JJ, Herzog DB. Cross-ethnic differences in eating disorder symptoms and related distress. *International Journal of Eating Disorders*. 2007; 40:156–164. [PubMed: 17080449]
- Glaser, B. *Gerund Grounded Theory: The Basic Social Process Dissertation*. Mill Valley, California, USA: Sociological Press; 1996.
- Glaser, BG.; Strauss, AL. *The discovery of grounded theory: Strategies for Qualitative Research* Chicago. Aldine; 1967.
- Hospers HJ, Jansen A. Why homosexuality is a risk factor for eating disorders in males. *Journal of Social and Clinical Psychology*. 2005; 24:1188–1201.
- Kempa ML, Thomas AJ. Culturally sensitive assessment and treatment of eating disorders. *Eating Disorders*. 2000; 8:17–30.
- Keyes KM, Martins SS, Hatzenbuehler ML, Blanco C, Bates LM, Hasin DS. Mental health service utilization for psychiatric disorders among Latinos living in the United States: the role of ethnic subgroup, ethnic identity, and language/social preferences. *Social Psychiatry and Psychiatric Epidemiology*. 2011; 47:383–394. [PubMed: 21290097]
- Marques L, Alegria M, Becker AE, Chen CN, Fang A, Chosak A, et al. Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health care access for eating disorders. *International Journal of Eating Disorders*. 2011; 44:412–420. [PubMed: 20665700]
- Mertens, DM. *Research and Evaluation in Education and Psychology*. Thousand Oaks, CA: Sage Publications Inc; 2005.
- Miranda J, Bernal G, Lau A, Kohn L, Hwang WC, La Framboise T. State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology*. 2005; 1:113–142.
- Mitchell, JE.; Pomeroy, C.; Adson, DE.; Garner, DM.; Garfinkel, PE., editors. *Handbook of Treatment for Eating Disorders*. New York: Guildford Press; 1997. Managing medical complications.
- Nadeem E, Lange JM, Edge D, Fongwa M, Belin T, Miranda J. Does stigma keep poor young immigrant and U.S. born Black and Latina women from seeking mental health care? *Psychiatric Services*. 2007; 58:1547–1554. [PubMed: 18048555]
- NVivo. (March 2008). (Vol. Version 8): QSR International.
- Olivardia R, Pope HG Jr, Mangweth B, Hudson JI. Eating disorders in college men. *American Journal of Psychiatry*. 1995; 152:1279–1285. [PubMed: 7653681]
- Petrie TA, Greenleaf C, Reel I, Carter J. Prevalence of eating disorders and disordered eating behaviors among male collegiate athletes. *Psychology of Men & Masculinity*. 2008; 9:267–277.
- Reyes-Rodríguez M, Bulik CM. Toward a cultural adaptation of eating disorders treatment for Latinos in United States. *Mexican Journal of Eating Disorders*. 2010; 1:27–35. [PubMed: 22003472]
- Reyes-Rodríguez ML, Sala M, Von Holle A, Unikel C, Bulik CM, Camara-Fuentes L, et al. A description of disordered eating behaviors in Latino males. *Journal of American College Health*. 2011; 59:266–272. [PubMed: 21308586]
- Sanchez-Johnsen LAP, Hogan K, Wilkens LR, Fitzgibbon ML. Correlates of problematic eating behaviors in less acculturated Latinas. *Eating Behavior*. 2008; 9:181–189.
- Sberna Hinojosa M, Hinojosa R, Nelson DA, Delgado A, Witzack B, Gonzalez M, et al. Salud de la mujer: using fotonovelas to increase health literacy among Latinas. *Progress in Community Health Partnerships*. 2011; 4:25–30. [PubMed: 20364075]

- Seijo R, Gomez H, Freidenberg J. Language as communication barrier in medical care for Hispanic patients. *Hispanic Journal of Behavioral Sciences*. 1991; 13(4):363–376.
- Snowden LR, Yamada AM. Cultural differences in access to care. *Annual Review of Clinical Psychology*. 2005; 1:143–166.
- Strauss, A.; Corbin, J. *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage; 1990.
- U.S. Department of Health and Human. *Mental Health: Culture, Race, and Ethnicity: - A supplement to Mental Health: A Report of the Surgeon General*. Rockville, Maryland: U.S. Department of Health and Human Services, Substance Abuse and mental Health Services Administration, Center for Mental Health Services; 2001.
- Walsh JM, Wheat ME, Freund K. Detection, evaluation, and treatment of eating disorders the role of the primary care physician. *Journal of General Internal Medicine*. 2000; 15:577–590. [PubMed: 10940151]
- Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*. 2007; 370:841–850. [PubMed: 17826169]
- Williams PM, Goodie J, Motsinger CD. Treating eating disorders in primary care. *American Family Physician*. 2008; 77:187–195. [PubMed: 18246888]
- Wilson PL, O'Connor DP, Kaplan CD, Bode S, Mama SK, Lee RE. Relationship of fruits, vegetable and fat consumption to binge eating symptoms in African American and Hispanic or Latina women. *Eating Behavior*. 2012; 13:179–182.
- World Health Organization. *Mental Health: New Understanding*. New Hope, World Health Report; Geneva: 2001.
- Woodward AM, Dwinell AD, Arons BS. Barriers to mental health care for Hispanic Americans: a literature review and discussion. *Journal of Mental Health Administration*. 1992; 19:224–236. [PubMed: 10128770]
- Yager, JDM.; Halmi, KA., et al. *Work Group on Eating Disorders. Practice Guideline for the Treatment of Patients with Eating Disorders*. Washington, DC: 2006. [Accessed June 28, 2007.]

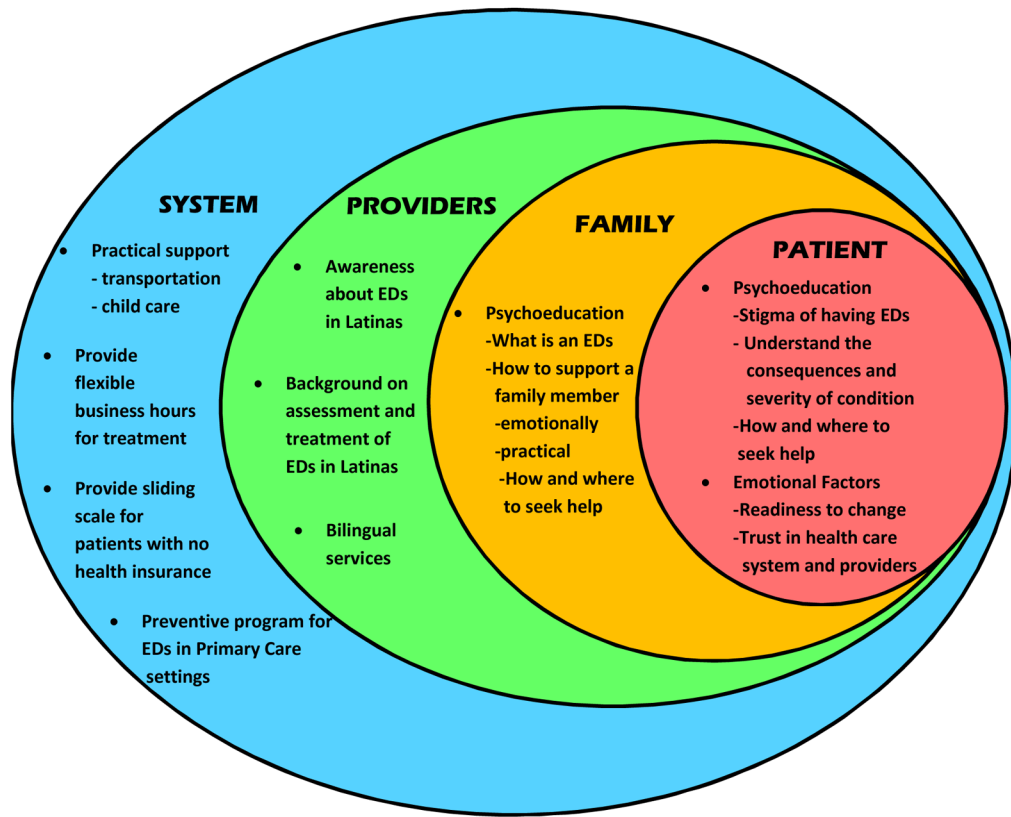


Figure 1.
Eating disorders treatment for Latinas: Level of intervention model

Table 1

Guided Questions for Participants

Questions	Areas of Domain
Patients	
What are the major needs of Latinos in terms of mental health services?	General needs
What kind of treatment do you think would be most acceptable to people in the Latino community?	General needs
Which factors could facilitate the process of seeking professional help for an eating disorder?	Facilitators in the ED treatment
Which factors help people engage in the treatment process?	Facilitators in the ED treatment
Which factors do you think influence whether someone stays in treatment and completes their treatment effectively?	Facilitators in the ED treatment
Which factors could make the process of seeking and receiving professional help more difficult?	Barriers
How comfortable are you seeking help for emotional problems?	Barriers
Have you had the opportunity to talk to your family or friends about your eating disorder?	Family support
Do you feel confident talking with your friends or family about your eating disorder?	Family support
Have you received support from your family or friends about seeking professional help?	Family support
Do you think that the eating disorder has affected your relationships with your family?	Family support
How important is it for you and for your treatment to receive support from your family?	Family support
What kind of support do you expect from your family?	Family support
Do you think that it is helpful to have your family involved in the treatment process?	Family support
Do you think that your family would be willing to participate with you in your treatment?	Family support
What kind of intervention would be helpful for you and for your family members in order to provide support for everyone?	Family support
What topics do you think should be included in a treatment that explores family factors and eating disorders?	Family support
What other types of help or support do you seek out for mental health care?	Other sources of support
Do you receive support from Latino community programs?	Other sources of support
What kind of support from the Latino community would be helpful for you?	Other sources of support
While living in the United States, have you had the need to seek help for eating disorders or any kind of emotional problem?	Previous experience
Describe your experience with treatment and with your provider	Previous experience
Did you find the help that you were looking for?	Previous experience
What would you have preferred to be different in your treatment?	Previous experience
What do you expect when you are seeking help for eating disorders or mental health problems?	Expectations
What do you expect of a mental health provider?	Expectations
What are your expectations of treatment?	Expectations
Providers	
Based on your experience, what factors have made it easier to engage Latinos in treatment?	Facilitators to engage and retention
What has your experience been with retention of Latinos in treatment?	Facilitators to engage and retention
What factors do you think contribute to the retention of Latinos in treatment?	Facilitators to engage and retention
What are the most common barriers that keep Latinos from engaging in treatment?	Barriers
Based on your experience, what factors contribute to the premature dropout of Latinos from treatment?	Barriers
What experience have you had working with Latinos and their families?	Family dynamics
How often have you had the necessity to include other family members in treatment for some specific reason?	Family dynamics

Questions	Areas of Domain
How feasible is it to include family members in treatment?	Family dynamics
Based on your experience, how is treatment seeking related to family issues (family issue as a main problem)?	Family dynamics
Typically, do Latinos come to treatment with any expectations about the duration or format of treatment?	Treatment expectations
Typically, do you think that these expectations influence the early drop out of Latinos or their retention in treatment?	Treatment expectations
What is your experience with evidence-based treatment?	Delivering evidence based treatment and treating EDs
Do you have experience treating eating disorders?	Delivering evidence based treatment and treating EDs
How comfortable do you feel treating someone with an eating disorder?	Delivering evidence based treatment and treating EDs
How willing are you to receive training in evidence-based treatments for eating disorders?	Delivering evidence based treatment and treating EDs
After receiving training, would you be willing to treat a person with an eating disorder?	Delivering evidence based treatment and treating EDs

Table 2

Summary of themes from mental health providers and Latinas with history of eating disorders

Themes	In-depth Interviews	
	Latina Patients	Mental Health Providers
Immigration Stress		
Lack of economic independence	+	-
Lack of family and friends support	+	+
Treatment Experiences in U.S.		
Lack of bilingual services	+	-
Lack of information about ED	+	+
Lack of group support	+	-
Facilitators to Seek-help		
Help from others	+	-
Perceived severity of condition	+	+
Emotional distress	+	+
Practical facilitators (flexibility in office hours and cost)	+	+
Barriers to Seek-help		
Lack of information about ED	+	+
Language	+	+
Economic Barriers (lack of insurance, lack of resources)	+	+
Emotional/Personal Barriers (fear of not being understood, not ready to change)	+	+
Cultural Stigmas	+	+
Transportation	-	+
Treatment Needs/Expectations		
Therapist who can understand (Someone to talk to in confidence)	+	+
Judgment-free sessions	+	+
Safe environment	+	+
Facilitators to Retain into Treatment		
Short-term treatment	-	+
Directive treatment	-	+
Support from family and friends	+	+
Avoid family member suffering	+	-

Table 3

Excerpts from in-depth interviews with mental health providers and Latinas with history of eating disorders

Theme	Source	Quotes
Immigration Stress		
-Economic dependence	Patient-01	"...en este país es...muy difícil encontrar un empleo...yo siempre he sido independiente por mi misma, entonces, depender de mi esposo se me hizo difícil...no tener dinero y pedirle a él, esas son cosas muy difíciles para mí." [In this country...it's very hard to find a job...I've always been independent, so depending on my husband is very hard for me...not having money and asking him for it, these are very difficult things for me].
-Feelings of Loneliness	Patient-02	"El primer año que llegué fue difícil." [The first year I arrived was difficult.]
-Language barriers	Patient-03	"So me siento like muy sola." [So I feel like very lonely.] "Todavía batallo con adaptarme aquí." [I still have difficulty adjusting here.] (After 5 years in U.S.)
-Language barriers	Patient-08	"...lo más difícil es adaptarse u otro país, u otro idioma. De hecho casi no lo...hablo." [...the hardest thing is adapting to a new country or a new language. In fact, I barely...speak it (English)] "...un poquito difícil al principio, por el idioma...era muy diferente." [...a little bit hard, at the beginning, due to the language....it was very different] (from her native country).
-Lack of support	Provider-05	"...porque desafortunadamente la gente que a veces vienen con más problemas son los que no tienen apoyo familiar...no tienen familia aquí." [Unfortunately the people who sometimes come in with the most problems are the ones who don't have family support...they don't have family here].
Treatment experience in U.S.		
-Lack of information /misperception about ED in Latinas	Patient-01	"...aquí es muy difícil porque casi no sé si hay personas que lo padezcan...aquí es muy difícil encontrar ayuda..." [...here it's very difficult because I almost don't know if there are people that have it...here it's very hard to find help...].
-Stigma about ED		"...en mi estaba como, ¿Por qué dije eso? No hubiera tocado ese tema... me hubieran ayudado con la depresión." [... I was like, why did I say that? If I hadn't brought it up, they would have helped with the depression"].
-Lack of professional support	Patient-06	"...yo intenté buscar ayuda y llamé a una clínica de, la información sobre bulimia o anorexia o donde podría obtener yo más ayuda...la llamada fue muy frustrante porque... la recepcionista me pregunta, ¿Tú estás segura que itenes un problema? ¿Te lo han diagnosticado?... cuando escuchas esas preguntas solo, dije "No" y colgué y seguí mi vida... como siempre". [...I tried to look for help and I called a clinic about information on bulimia or anorexia or where I could get more help... the call was very frustrating because... the receptionist asked me, 'Are you sure that you have a problem?' Have they diagnosed you?' ...when I heard those questions I said 'No' and hung up and continued my life like always].
-Clinician bias about ED in Latinas		"...tuve la misma experiencia con el dentista cuando los dientes se me habían desgastado bastante... me dijo el dentista, "Wow, ¿qué es lo que estás comiendo?"; Y le dije, "Bueno, me gusta mucho el limón" y me quedó pensando y le dije, "I think I'm bulimic", y también la respuesta fue nada." [...I had the same experience with the dentist when my teeth had worn away a...the dentist said to me, 'Wow, what is it that you're eating?' and I told her, 'Well, I really like lemon.' And I kept thinking and I told her, 'I think I'm bulimic,' and again, no response].
-Language barriers	Patient-08	"...aparte la interprete...me decía lo que me decía ella [interprete] pero aparte me decía lo que ella [interprete] pensaba de lo que yo le decía entonces era...difícil... no solamente tener que contarles mis cosas al psicólogo...pero con un intérprete también, que no tenía nada que ver...no me gustó mucho eso así" [Patient-08]. [The interpreter would tell me what she [the therapist] was saying to me but would also tell me what she [the interpreter] thought about what I was saying so it was...difficult...not only having to tell my issues to the psychologist...but also with an interpreter as well, that had nothing to do with it...I didn't really like that]

Facilitators to seek help

Theme	Source	Quotes
-Severity of condition	Patient-01	" <i>Cuando una vez que vomito sangre, fue cuando me asusté, o sea, ¿qué está pasando en mí?</i> " [When I vomited blood one time that was when I got frightened. I thought, what's happening to me?].
-Family support		"...a veces tirada en la cama, entonces me ayudaron a buscar ayuda." [...at times I was unable to get out of bed, so they [sisters and friends] helped me look for help].
-Severity of condition	Patient-02	"...yo me sentía bien sola...era mucho y me, me puse un tiempo que estaba en un, "deep depression"...hablar con otra persona me ha ayudado. 'You know,' cuando hablo de mi situación o hablo de mis cosas, me siento como un 'relief'" [...I felt so alone...it was a lot and for a time I was in a deep depression... talking to someone has helped...when I talk about my situation, I feel a sense of relief].
-Familism		"... no me quiero morir. Y digo me voy a morir de por, obesa, so no miraba el chiste pues voy a dejar a mi hijo, ¿Y después quien va a ver a velar por él?" [...I don't want to die. I told myself I'm going to die of, due to obesity, if I didn't "see the point", well then I'm going to leave my son. And afterwards, who's going to watch over him?].
-Support from others/personalism	Patient-06	"...creo que el, el saber que no, el saber que no estamos solos, creo que eso es..." [... I think that, knowing, knowing that we're not alone, I think that is...].
-Bilingual services	Patient-08	"...creo que como, es más fácil en español porque uno tiene, bueno, independencia. Mis sentimientos los sé decir mejor en español que en inglés decirlo en inglés tengo que o buscar un diccionario algo que está relacionado más a lo que yo siento o, o tratar de explicarla con las palabras que ya conozco pero es un poquito más difícil." [...I think it's easier in Spanish because one has, well, independence. I can communicate my feelings better in Spanish than English...to say it in English I either have to search in the dictionary for words that are related more so to what I'm feeling or I have to try to explain with the words I already know but it is a little more difficult].
-Business hour flexibility	Provider-04	"También siento que es importante ser bastante flexible en el horario." [I also think that it's important to be very flexible with scheduling].
-Reminder appointment calls		"Y yo sé que hay como la fama que los latinos muchas veces llegan tarde...pero realmente yo siento que eso pasa no muy seguido...la gente es muy cumplido, la gran mayoría, pero... es importante como llamarlos el día antes o dos días antes a recordarles..." ["I know that there is the preconceived notion that Latinos many times arrive late...but I feel like this doesn't happen many times in a row....The large majority are very punctual, but...it's important to call the day before or two days before to remind them].
-Trust relationships	Provider-07	"...obviamente una visita médica con un médico de confianza, una persona de confianza... miembro de familia" [...obviously a visit with a doctor with a trustworthy doctor, a trustworthy person... a family member].
-Accessible services	Provider-09	"Yo creo que porque se base en lo económico...en la accesibilidad de servicios... y la distancia porque también en Siler City tengo pacientes que no hay otros recursos y una paciente, yo creo que manejé dos horas a venir a sus citas y después de dos, tres veces y la chava está ya, no." [I think it's because it has an economic basis...in the accessibility of services,...and in the distance because I also have patients in Siler City who don't have other resources and a patient.I think drove two hours for her appointments and after two, three times she was like, no].
-Business hours flexibility -Child care	Provider-10	"...lo más distinto [factores] pienso que son el horario y estar flexibles con [los pacientes] y la transportación y por las mujeres el cuidado de los niños" [Provider-10]. [...the most distinctive [factors] I think are the schedule and being flexible with [patients] and the transportation and for women childcare].
Barriers to seek help		
-Lack of bilingual services	Patient-01	"...a donde yo fui no tenía esa persona que hablara español... yo sentí así como muy difícil como que, en este país no padece nadie de esa enfermedad..." [...where I went they didn't have someone who spoke Spanish...I felt like it was very difficult like, that in this country no one suffers from this illness...].
-Lack of information about Services	Patient-02	"Yo creo que es básica más en información y, y tal vez, el idioma. Que muchos no saben lo que hay, para la ayuda de latinos no hay como, como tener esa información, o como tener esa ayuda." [I think it's more basic in information and, perhaps even, in language. Many do not know what there is, for resources for Latinos there isn't a way, a way to get that information or a way to receive that help].
-Perceived severity of condition	Patient-03	"Si yo sé que es un problema, pero no sé...no lo veo como algo muy grave." [Yeah I know it's a problem, but I don't know...and I don't see it as something very serious].

Theme	Source	Quotes
-Feeling like a "guinea pig" with resident students		"...y a veces tengo que ir a la clínica y no voy, porque a veces tengo que estar horas y horas porque pasa uno, pasa otro y así, así." [...and sometimes I have to go to the clinic and I don't go because sometimes I have to be there for hours and hours because one person comes in, and another, and so on and so on (medicine residents)].
-Mental health stigma	Patient-08	"...antes yo pensaba también que, que pensaban que estaba loca y que por eso necesitaba la ayuda... así como yo pensaba es que yo no estoy loca, yo no necesito ir con, con un psicólogo, yo no estoy loca. Y también eso influye mucho así, a veces pensaba estoy mal." [... before I used to also think that, that they (healthcare providers) thought I was crazy and that's why I needed help... likewise I thought I'm not crazy, I don't have to go see a psychologist, I'm not crazy. That also influences a lot, and sometimes I would think I'm not well].
-Economic barriers	Patient-04	"Un problema grande que a veces hay es la necesidad de cuidado de los niños... y transporte... es otro problema grande. A veces dependiendo de si tienen que pagar por los servicios, especialmente ahora que hay como un crisis económico... al nivel de los obreros. Hay mucha gente que estaban interesados en terapia y no quieren venir, porque no pueden pagar." [A big problem that exists is the need for childcare... and transportation... that's another big problem. Sometimes depending on whether they have to pay for the services, especially now that there is an economic crisis... among the working class. There are a lot of people that are interested in therapy but don't want to go because they can't afford it].
-Lack of training on EDs by providers		"Yo creo que no somos buenas para hacer las preguntas y mirar... una cosa es que no hacemos buenas preguntas, pero también creo que ninguno aquí sabemos mucho de cómo manejar la cosa... hay mucha inseguridad de cómo manejarlo y yo creo que no somos buenas en, en mirar bien profundo... si está pasando eso." [I don't think we're good at asking questions and looking... one thing is that we don't ask good questions, but I also think that none of us know how to handle the situation... there is much insecurity in handling the situation and I think we're not good at, at looking closely to see if that's happening (an ED)].
-Lack of transportation	Provider-10	"Algún factor a veces es la transportación. Tengo algunas clientes, que no manejan por caso de la ansiedad que tienen entonces por eso tienen que encontrar una persona para traerla cada cita. Oh también tengo... que usan... taxis, pero eso cuesta mucho entonces a veces la transportación es algo difícil... [One factor sometimes is transportation. I have some patients who don't drive because of anxiety, so then they have to find someone to take them to each appointment. Or I also have some... that use... taxis, but this costs a lot, so transportation is difficult...].
-Lack of health insurance		"También una cosa es la seguridad, tenemos muchos adultos aquí que necesitan terapias y citas semanales y por tal vez años de terapias porque tienen traumas muy complejos y todo eso, pero si no tienen seguridad... a veces solo pueden tener ocho sesiones por año. Entonces no es suficiente para ganar la confianza del cliente y, y empezar el, el tratamiento que necesitan." [Another thing is insurance. Obviously, we have many adults here who need therapy and weekly appointments, and maybe years of therapy because they have complex traumas and all that, but if they don't have insurance... sometimes they can only have eight sessions a year. And this is not enough to gain the client's trust and begin the treatment they need].
Treatment needs/ expectations		
-Emotional support	Patient-01	"Yo creo que... en mi caso es como buscar una persona que te entienda, que sepa entenderte, tu depresión o sin criticarte." [Patient-01]. [In my case it's like looking for a person who understands you, that knows how to understand you, your depression or without criticizing you]
-Support	Patient-02	"Yo digo que si una persona tiene apoyo... esa persona va a ser más fácil triunfar, y hacer las cosas mejor. Cuando una persona no tiene apoyo... "you're not gonna succeed better." [Patient-02]. [I'd say that if a person has support, this person is going to have an easier time succeeding, and doing things better. When a person doesn't have support, "you're not going to do as well"].
-Female therapist	Patient-03	"Bueno muchas, este mujeres, así que conozco, nos da más confianza platicar con una mujer que con un hombre. Porque luego hay terapistas que son hombres, como que no siente una esa confianza, no siente uno que lo va a entender más que una mujer." [Well] lots of women, that I know, we feel more comfortable talking with a woman than a man. Sometimes there are therapists that are men and one doesn't feel as comfortable, one feels like he will not understand us as well as a woman].
-Short term treatment	Provider-05	"Que en como dos veces van a venir y van a estar mejor. Entonces si vienen con esa idea a veces no duran tanto tiempo pero a veces, es, es difícil saber porque muy frecuentemente tengo pacientes que vienen una o dos veces y nunca vuelvan." [That in like two visits one will feel better. So if they come with that idea in mind a lot of times they don't last long but sometimes it's difficult to know because I frequently have patients that come one of two times and they never return].

Theme	Source	Quotes
-Relationship of trust and confidence	Provider-09	"Y yo creo que un factor es que la gente se siente bastante aislada y creo que cuando perciben que alguien se entiende o viene del mismo camino rumbo yo creo que se da un cierta este, confianza." [I think one factor is that they feel so isolated, and when they perceive that someone understands them or comes from the same place it gives them a certain confidence and trust].
-Short term treatment	Provider-10	"Pero también a veces pienso que hay expectativas que, que voy asistir tres citas y después de eso obviamente voy a sentir un poquito mejor..." [But also sometimes I think there are expectations that I will go to three appointments and after that I will obviously feel a little better...].
Facilitators to retain into treatment		
-Group support	Patient-03	"Me sentiría yo más cómoda que hubieran más, más grupo que estuviera hablando." [I would feel more comfortable if there were more, more group talks].
-Group support	Patient-06	"Para mí lo, lo que, ha sido absolutamente esencial es grupo." [For me, what has been absolutely essential has been group support].
-Education about treatment	Provider-05	"...yo creo que...está muy claro las expectativas de ellos en el sentido de cuanto tiempo van a venir, cuantas veces a la semana, cuanto se tiene que pagar, todo eso. Las expectativas de ellos, pero también las expectativas de los cambios...de que tal vez el progreso no es tan inmediato..." [...I think... the expectations are very clear to them in regards to the length of sessions, how many times they will come each week, how much they have to pay. Their expectations but also the expectations of the change... that maybe improvement may not be so immediate].
--Concrete focus treatment	Provider-09	"Depende de la gente pero yo creo que nuestra orientación con el latino es, es el tratamiento sea concreto." [It depends on the people but I think our focus is on a concrete treatment for the Latino].
-Education about treatment	Provider-10	"...pienso que puede ayudar a los latinos para retenerlos en las terapias si, si ellos entienden que, que hay etapas del... tratamiento. Y a veces van a sentir diferentes cosas y tener diferentes niveles de motivación durante esas etapas." [...I think it can help Latinos to stay in therapy, if they understand that there are stages in...treatment. And that sometimes they will feel different things and have different levels of motivation during these stages].