TREATMENT FOR ANOREXIA NERVOSA WITH LATINX CLIENTS:

A QUALITATIVE INQUIRY

by

AMELIA LYNN HOYLE

(Under the Direction of Edward Delgado-Romero and Linda Campbell)

ABSTRACT

Eating disorders are often mis-characterized as White women's disorders, and there is an erroneous belief that the prevalence of eating disorders in American women of color is rare. However, research suggests that Latinx individuals report levels of body dissatisfaction and eating problems similar to those of White women. Although increasing attention is being paid to the enhancement of multicultural competencies for mental health professionals (American Psychological Association, 2017), little research has explored the experiences for Latinx clients in engaging in traditional treatments for Anorexia Nervosa. This qualitative study examined the experiences of Anorexia Nervosa treatment for individuals who identify as Latinx. Utilizing a phenomenological perspective, a Reflective Lifeworld Research approach (Dahlberg, Dahlberg, & Nyström, 2008), this research explored Latinx individuals' cultural experiences of Anorexia treatment. Data analysis yielded two essences of the phenomenon: the experience of isolation, both from mental health professionals and from Latinx culture, as well as the experience of cultural competence. Implications for treatment providers include recommendations directly from participants for providing culturally competent Anorexia treatment to Latinx clients.

INDEX WORDS: Latinx; Anorexia Nervosa; culture; cultural competence; eating disorder treatment; disordered eating

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DEDICATION

This dissertation project is dedicated to the participants who openly shared their experiences with me. Thank you for trusting me – I hope this project honors your voices and the voices of those continuing to struggle with Anorexia. You are not alone.

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CHAPTER I

Introduction

Background and Context

An extensive amount of research literature has exposed the ubiquitous prevalence of body dissatisfaction in women, particularly around women's views of their weight and body shape (Tiggemann & Zaccardo, 2015). Sociocultural pressures, including the pervasive impact of mass media, have been pinpointed in the search for the exact cause of Anorexia Nervosa. Each new study reinforces the link between sociocultural pressures of the "thin ideal" in Western society with body-dissatisfaction, low self-esteem, and eating pathology (Bissell & Rask, 2010; Lopez-Guimera, Levin, Sanchez-Carracedo, & Facquet, 2010). Indeed, what is known about Anorexia Nervosa is the ability of this disorder to disable the individuals impacted by it, reducing quality of life (Renwick et al., 2015). Moreover, Anorexia Nervosa has the highest level of co-morbidity and the highest mortality rate among psychiatric disorders (Renwick et al., 2015).

Characterized pervasively as a White women's disorder, it has been historically assumed that the prevalence of eating disorders in American women of color is rare (Root, 1990). However, as Gilbert (2003) contended, "the prevalence of eating disorders among women of color may be on the rise as a result of increasing assimilation to White culture" (p. 444). Women of color may be at risk for the development of eating disorders when their culture's concept of beauty conflicts with Western norms (2003). As the evidence grows describing the increasing rates of eating disorders for women of color, the myth that White upper-class women and girls are the only ones who experience eating disorder is slowly being dispelled (2003). Indeed,

research suggests that Latinx[1] women report levels of body dissatisfaction and eating problems similar to those reported by White women (2003).

However, the defining features of Anorexia Nervosa may not seamlessly apply to women of color. As Franko (2007) noted, many women of color receive the "not otherwise specified" DSM diagnosis, suggesting that symptomology may vary depending on the individual's cultural context. This variation may play a role in the recommendation or referral of women of color to psychotherapy treatment for eating disorders. For instance, research findings from Gordon, Perez, and Joiner (2002) suggested that undergraduates were more likely to recognize eating disorder symptomology in a peer if the written description was of a Caucasian peer, rather than an African American or Latinx peer. Clinicians may experience a similar inclination towards racial stereotyping; a recent study contended that Latinx and Native American women are less likely than White women to receive a recommendation or referral for eating disorder evaluation and care, despite the lack of difference in eating disorder symptoms between the participants (Becker, Franko, Speck & Herzog, 2003; Palmer, 2007). Psychotherapy clinicians may fail to recognize and treat individuals with eating disorders who do not present with the traditional symptomology based on the experiences of White women (Gilbert, 2003; Palmer, 2007). As Talleyrand (2012) stated, "traditional screening and counseling approaches used to examine and treat women's eating disorder symptoms may not necessarily capture the unique sociocultural experiences of women of color" (p. 271). While the current study will focus specifically on the experiences of treatment for Anorexia Nervosa, the following manuscript will draw on broader eating disorder research in order to explore unique cultural considerations for people of color.

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[1] *Latinx* will be used as an alternative to Latino/Latina/Latin@. The term is inclusive of intersecting identities and moves away from the assumption of a gender binary (Ramirez & Blay, 2016).

Justification for the Present Study

Experts in the field of disordered eating have implored researchers to study etiology and treatment of eating disorders in women of color (Smart, Tsong, Mejia, Hayashino, & Braaten, 2011). Research suggests that etiology of eating disorders may vary by racial and ethnic group, age, immigration status, ethnicity, and acculturation (Capodilupo & Forsyth, 2014). Increasing attention is being paid to the enhancement of multicultural competencies for mental health professionals, ensuring that services are provided which align with clients' cultural concerns and experiences (Palmer, 2007). However, little research has explored the experiences for women of color in engaging in traditional treatments for Anorexia Nervosa, such as Cognitive Behavioral Therapy (2007). Clinicians are warned in the literature to proceed cautiously in deciding whether traditional approaches are effective for the treatment of Anorexia Nervosa for women of color (Palmer, 2007; Gilbert, 2003).

When women of color are recommended to therapy for the treatment of eating disorders, concerns related to prejudice and discrimination may be overlooked in the therapy relationship. This may be detrimental in reinforcing the stigma surrounding mental health therapy, which is pervasive in communities of color, and may ignore important cultural concerns relevant to treatment. As Gilbert (2003) wrote, "women of color may have issues related to racism, sexism, and an oppressive standard of beauty that perpetuates body dissatisfaction, dieting, and self-hatred" (p. 450). Gilbert (2003) goes further to say that the discussion of stereotypes of women of color in the therapy room may be helpful in assisting clients to examine belief systems. Direct and honest discussions of client-therapist differences may be necessary in psychotherapy treatment of eating disorders for women of color. As Gilbert (2003) stated, "White therapists may be viewed as part and parcel of the culture that promotes the Eurocentric, thin standard of

beauty" (p. 450). Infusing cultural strengths and values into therapy may also be an important tool in the provision of culturally competent therapy for women of color. For Latinx clients, exploration of spiritual and religious beliefs may be useful in treatment, depending on the importance of spirituality in the client's life (2003).

Additionally, research suggests that Latinx women may embrace a multifaceted body ideal, emphasizing hygiene and grooming, style, health and spirituality over traditional beauty norms (Rubin, Fitts, & Becker, 2003). Palmer (2007) suggested that "clinicians should take the time to understand the client's worldview to learn how issues of race, culture, and ethnicity may impact their experiences" (p. 34). Indeed, non-traditional interventions may be utilized by multiculturally competent treatment providers, as techniques are continually adjusted based on cultural appropriateness (2007). As the APA Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality (2017) suggested, psychologists must strive towards applying culturally-appropriate psychological applications in clinical work. The authors described the importance of culturally adaptive interventions, which exhibit cultural awareness and knowledge of cultural aspects (APA, 2017; Zayas, Torres, Malcolm, & DesRosiers, 1996). Clinicians must have a broad repertoire of intervention tools when working with culturally diverse clients.

While literature pertaining to treatment of eating disorders in women of color is scarce, Smart, Tsong, Mejia, Hayashino, and Braaten (2011) have demonstrated the possibilities for qualitative research in understanding treatment challenges and adaptations. By utilizing a grounded theory approach, these researchers used semi-structured interviews to investigate therapists' experiences of treating Asian American women with eating disorders. Smart et al. (2011) were able to explore conceptualization of eating disorders within a cultural context, as

well as specific treatment approaches. This qualitative approach allowed researchers to hear the ways in which therapists were able to adapt their therapeutic style in order to best suit the needs of their Asian American clients (2011). The findings of this research suggest that “the meaning of thinness for some Asian American women may involve deeply rooted beliefs of honoring the family, through one’s presentation and achievement, particularly in the process of adapting to the U.S., and conforming to both cultures in such a way that one does not stand out” (Smart et al., 2011, p. 312). Without qualitative work such as this research, experts in eating disorders might not be aware of the importance of including families in treatment, sensitivity to cultural norms, and the need to attend to acculturative stress. Findings from this study and others emphasize how essential it is to explore the cultural context of the individual with an eating disorder, recognizing that eating disorders may involve more than body dissatisfaction and the desire to be thin (2011). This research also emphasizes the necessity of examining within-group differences; women of color are often considered as a “comparison group” instead of exploring the similarities and differences of specific racial and ethnic groups (Talleyrand, 2012). Comparison research continues to prevail in current research. In 2016, Hall, Yip, and Zárate outlined three perspectives for research with diverse groups: the generalizability approach, a group differences approach, and multicultural psychology. Through the “group differences approach,” researchers make comparisons between groups that are “assumed to represent different cultures” (2016, p. 44). The reference group in this approach is often White women. Attentiveness to this largely overlooked area of eating disorder research may “contribute to the provision of culturally competent assessment, prevention, treatment, and counselor training” (Talleyrand, 2012, p. 278).

Purpose Statement

As Capodilupo and Forsyth (2014) stated, "very little effort has been made to attempt to understand women of color's lived experiences of body image and eating issues outside and apart from existing theories validated with White women" (p. 343). Moreover, while Latinx individuals represent a growing majority of the U.S. population, Latinx clients are largely underrepresented in the eating disorder literature (Talleyrand, 2012). Therefore, the purpose of this study was to examine Latinx clients' experiences of eating disorder treatment for Anorexia Nervosa. Specifically, this research sought to explore Latinx clients' cultural experiences of eating disorder treatment for Anorexia Nervosa. To truly encompass cultural experiences, potential areas of interest for interview dialogues included discussions in therapy of client-therapist cultural differences, racism, discrimination, oppression, acculturation, cultural values and strengths, intersection of salient identities, as well as what Latinx clients would have liked to have been addressed in therapy surrounding culture.

Definitions

Anorexia Nervosa (*AN*): Characterized by restricting energy intake that leads to a significantly low body weight (i.e., lower than what is minimally expected for age, sex, physical health, and development), intense fear of weight-gain or becoming fat, and behavior that interferes with weight gain (American Psychiatric Association, 2013).

Disordered Eating: Maladaptive eating behaviors that reflect many but not all of the symptoms of a clinically diagnosed eating disorder.

Feeding and Eating Disorders (*ED*): The *DSM-V* (APA, 2013) category that includes the diagnoses of Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, Other Specified Feeding or Eating Disorder, and Unspecified Feeding or Eating Disorder.

Other Specified Feeding or Eating Disorders (*OSFED*): This category, formerly called Eating Disorder Not Otherwise Specified (EDNOS) in the DSM-IV (APA, 2003), describes feeding and eating disorders of clinical severity that do not meet the diagnostic criteria for Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, or Binge-Eating Disorder. For the purposes of this study, one participant self-reported a previous diagnosis of EDNOS, with symptoms of restriction.

Latinx: This term will be used as an alternative to Latino/Latina/Latin@; it is inclusive of intersecting identities and moves away from the assumption of a gender binary (Ramirez & Blay, 2016).

Recovery: For the purposes of this study, recovery was self-reported and referred to 1) previously having met criteria for Anorexia Nervosa, and 2) no longer meeting criteria for Anorexia Nervosa at the time of recruitment.

Research Questions

1. What are the cultural experiences of Latinx clients in eating disorder treatment for Anorexia Nervosa?
2. What perceptions do Latinx clients have regarding the cultural competence of therapists for the treatment of Anorexia Nervosa?
3. In what ways, if any, do Latinx clients believe cultural factors played a role in engaging in treatment for Anorexia Nervosa?

Organization of the Manuscript

The following manuscript includes a review of the literature, a description of the research methods, a summary of the results, and a discussion of the findings. Chapter II, Review of Relevant Research, is organized into two sections: an overview of disordered eating and Anorexia Nervosa and Latinx clients and Anorexia Nervosa. Chapter III will explain the research design, describe researchers' positionalities and discuss procedures and participants. Chapter IV will present the results of the study, including two main essences of the phenomenon, isolation and cultural competence. Costs of culturally incompetent treatment will also be explored. Lastly, Chapter V will summarize the findings, describe implications, and provide recommendations for future research, as well as limitations to the current study.

CHAPTER II

Review of Relevant Literature

Overview of Disordered Eating and Anorexia Nervosa

This review of the literature begins with an overview of concepts including objectification theory and self-objectification, disordered eating and Anorexia Nervosa. Next, Latinx clients and Anorexia Nervosa will be explored. This section begins with the literature's description of assumed protective factors for Latinx individuals and is followed by a review of race and oppression, internalization, and acculturation as related to eating disorders and treatment. Next, the current understandings around eating disorder treatment seeking and misdiagnosis for Latinx clients will be considered, as well as the impact of including Latinx cultural values in therapy.

Objectification Theory and Self-Objectification

Objectification theory refers to the concept of evaluating an individual as an object for the use and pleasure of other people (Fredrickson & Roberts, 1997). Fredrickson and Roberts' (1997) objectification theory described the concept of women being treated as an object valued primarily for its use to others as a unique experience influenced by the cultural and interpersonal experiences of the individual. When women experience such sexual objectification, they are socialized to engage in self-objectification, in which they begin to adopt an observer's perspective of their physical selves (1997).

Self-objectification is a fluid concept, which differs across women and has the ability to fluctuate over time; therefore, state self-objectification may increase in situations that bring

awareness of an observer's perspective of the body (Fredrickson et al., 1997). A host of negative outcomes have been associated with self-objectification, including appearance anxiety (Tiggemann & Slater, 2001), body shame (2001), disordered eating (2001), decreased intrinsic motivation and self-efficacy (Gapinksi, Brownell, & La France, 2003), and depression (Tiggemann & Kuring, 2004).

Disordered Eating

Restrictive dieting is viewed as a normative behavior for girls and women (Root, 1990). In a society in which a woman's physical appearance is praised as her most valued attribute, a heightened focus on physical appearance can often become a gateway to acceptance (1990). In this way, dieting becomes a strategy by which women can obtain power and acceptance in U.S. society (1990). When looking at the factors that drive disordered eating behavior, several psychological themes emerge: "the pursuit of identity, power, specialness, validation, self-esteem, and respect" (Root, 1990, p. 526). Important to note about these themes is their applicability in the lives of oppressed persons, as individuals from marginalized groups strive to maintain control in the face of oppressive systems.

Anorexia Nervosa

Anorexia Nervosa (AN) is characterized by restrictive eating that leads to a significantly low body weight (i.e., lower than what is minimally expected for age, sex, physical health, and development), intense fear of weight-gain or becoming fat, and behavior that interferes with weight gain (American Psychiatric Association, 2013). Moreover, individuals with Anorexia demonstrate a disturbance in the way in which their body weight or shape is experienced, over-emphasis on body weight and shape on self-evaluation and self-perception, and a lack of recognition that low body weight is significant or serious (2013).

Latinx Clients and Anorexia Nervosa

The research on Anorexia Nervosa has been derived, almost exclusively, from White, upper to middle-class women in their teens and early twenties (Root, 1990; Capodilupo & Forsyth, 2014). As such, the criteria surrounding diagnosis of this disorder has been based almost solely on research that did not include women of color in their investigations (Gilbert, 2003). Due to this emphasis on White women's experiences of disordered eating, concepts such as the "thin ideal" have been applied to body dissatisfaction as if they were universal (Capodilupo & Forsyth, 2014). According to models pertaining to the "thin female beauty ideal," women internalize a thin ideal and engage in comparisons to this ideal which leads to body dissatisfaction (Gilbert, 2003). This dissatisfaction places the individual at risk for the development of an eating disorder (2003). However, models of the "thin ideal" may not capture the unique experiences of women of color and the impact of intersecting identities in the development of eating disorders.

The limited research surrounding eating disorders and women of color has yielded contradictory results. While some research suggests that women of color experience the drive for thinness and experiences of body dissatisfaction at similar or even higher rates than reported by White women, others suggest a negligible prevalence of eating disorders for women of color (Gilbert, 2003). For instance, a 2007 research study described the prevalence for Anorexia Nervosa among Latinx women as .08% and the rate for Latinx men as .03% (Alegría, Woo, Cao, Torres, Meng, & Striegel-Moore, 2007). While there is no consensus in the research literature, studies report the lifetime prevalence rates for Anorexia Nervosa overall to range from 1.7% to 3.6% (Dahlgren, Wisting, & Rø, 2017).

Methodological concerns have arisen in the existing literature on body image and women of color, including the use of measures for women of color that have not been normed on them. There appears to be little effort to validate eating disorder measures on women of color in the United States (Capodilupo & Forsyth, 2014). Additionally, the existing research on disordered eating that utilizes women of color in their samples appears to use women of color for comparison purposes, with women of colors' experiences being compared to the "norm" of the White female experience (2014). Moreover, as Hall, Yip, and Zárate's (2016) highlight, researchers will often utilize samples of women of color that do not describe the demographic characteristics of the sample; as such, researchers often use samples that are generic, describing the sample simply as "women of color" instead of pointing out variability within the sample.

Due to this limited focus on women of colors' experiences, particularly in looking at differences within groups, criteria of Anorexia Nervosa that highlights "drive for thinness" and "fat phobia" may ignore other factors related to motivation for weight loss (Capodilupo & Forsyth, 2014). As Palmer contended, "assuming Anorexia symptomatology in women of color is purely appearance-based can camouflage underlying emotional issues and relationships" (Palmer, 2007, p. 25). By focusing solely on weight and shape, researchers may be overlooking key aspects that influence body satisfaction for women of color (Capodilupo & Forsyth, 2014).

A study conducted by Shaw, Ramirez, Trost, Randall, and Stice in 2004 illustrated this discrepancy by examining eating disorder symptoms in a sample of 785 adolescent and adult African American, Asian American, Latinx, and White females. While African American and Latinx females did not appear to internalize the thin ideal to the extent of their White and Asian American counterparts, researchers did not detect differences in their report of risk factors associated with eating disorders, nor differences in reports of eating disorder symptoms (Shaw et

al., 2004). These symptoms included fear of becoming fat, weight concerns, and compensatory behaviors (Shaw et al., 2004). Therefore, while Latinx and African American women may not internalize the traditional concept of the "thin ideal," they may still engage in disordered eating behaviors that could lead to a diagnosis of an eating disorder. Although it has been assumed that Latinx and African American women may possess protective traits that prevent the development of eating disorders, current research suggests Latinx and African American women are reporting body dissatisfaction and eating behaviors that are characteristic of Anorexia Nervosa (Talleyrand, 2012).

Protective Factors

As noted previously, some research suggests women of color experience less pressure to conform to the "thin ideal" of beauty compared to White women (Gilbert, 2003). Previous eating disorder literature has gone as far as to say that women of color experience invulnerability through the protective factors of their racial or ethnic group. This has led to the assumption in the eating disorder literature that women of color have protection against dominant American standards of beauty and, therefore, are not susceptible to societal messages hailing the importance of weight loss (Palmer, 2007). As Palmer (2007) stated:

> Women of color were thought to be reluctant to accept, identify, and internalize ideals of dieting and thinness in mainstream Western culture (Gilbert, 2003); they may experience less social pressure to conform to thin ideals than White women (Childress, Brewerton, Hodges, & Jarrell, 1993; Powell & Kahn, 1995; Striegel-Moore, Schriber, Pike, Wilfley, & Rodin, 1995); they are less rigid and more flexible than European American women regarding their notions of beauty (Parker, Nichter, Vuckovic, Sims, & Rittenbaugh, 1995); they have more role models and kinship networks protecting them from looking to

> media for self-other comparisons (Greene, 1994); and they are more likely to describe beauty in terms of personality traits as opposed to physical characteristics (Landrine, Klonoff, & Brown-Collins, 1992; Parker et al., 1995) (p. 30).

However, this outdated conceptualization of protective factors offers a limited understanding of the complex context within which people of color experience body image and self-concept. Indeed, some research indicates that girls and women of color have levels of body dissatisfaction and drive for thinness on par or greater than their White counterparts. Indeed, Neumark-Sztainer et al. (2002) suggested that Asian and Latinx girls experience greater body dissatisfaction compared to White girls.

Race and Oppression

An overreliance on the thin ideal may also overlook the potential power of food refusal as “an attempt to free oneself from the control of others” (Katzman & Lee, 1997, p. 389). These attempts to reclaim control and power of the body may function as a method of coping with the isolation that accompanies experiences of prejudice, discrimination and oppression. However, there is a dearth of research that examines the role of racial and ethnic discrimination in the development of body dissatisfaction and disordered eating (Capodilupo & Forsyth, 2014).

Importantly, the intersection of identities cannot be ignored when considering women of colors’ simultaneous membership to two oppressed demographic identity groups: both gender and race (Talleyrand, 2012). When studying the recovery from disordered eating for Latinx, Black, and White women, Thompson (1994) found that many participants traced the onset of their eating disorder to stressful or traumatic experiences. Food served as a mechanism to cope with experiences of racism and sexism (1994). Moreover, oppression experienced by people of color may be compounded by specific instances of discrimination surrounding their bodies and

facial features not being consistent with the dominant culture's beauty ideals (Gilbert, 2003). All in all, the risk factors for eating disorders may differ for women of color due to the roles of racism, discrimination, and acculturative stress (Gilbert, 2003).

Internalization

Eating disorders may not only function as a way to cope with individual racism and discrimination but may also demonstrate efforts by some women of color to negotiate two different cultures, their culture-of-origin and the dominant culture. This can be viewed as a broader form of oppression and discrimination, as a woman's culture of origin may clash with the values and ideals of the mainstream culture leading to internalization (Palmer, 2007).

As Harris and Kuba (1997) wrote, a woman's concept of beauty is primarily shaped by her culture of origin. However, "it may be problematic when her cultural concept of beauty is in conflict with the definition put forth by another culture" (1997, p. 342). Women of color are still subject to the standards of the dominant culture and are especially influenced by these standards when their culture is devalued by the dominant culture (Root, 1990). When their concept of beauty and attractiveness conflicts with that suggested by the dominant culture, women of color may struggle with competing cultural norms surrounding physical appearance leading to increased levels of body dissatisfaction and risk for the development of eating disorders (Talleyrand, 2012; Gilbert, 2003). In an effort to reconcile these discrepant ideologies, women of color may begin to adopt attitudes and behaviors consistent with the dominant culture, rejecting their own culture's standards (Gilbert, 2003). Indeed, there can be varying degrees by which women of color internalize White cultural beauty standards (Capodilupo & Forsyth, 2014). The most detrimental internalizations may lead to increased levels of body dissatisfaction and risk for the development of eating disorders (Talleyrand, 2012; Gilbert, 2003). In a 2015 study by Velez,

Campos, and Moradi, analysis indicated that internalization of sociocultural standards of attractiveness was related to greater eating disorder symptomatology.

Acculturation

Acculturation, in relationship to Anorexia Nervosa, can be understood as the acceptance of White cultural beauty standards (Capodilupo & Forsyth, 2014). Traditionally understood in terms of generation and amount of time in the United States, acculturation has been previously viewed as a linear and unidirectional process in which individuals adhere entirely to the cultural values of their host culture, primarily in their preference for food, music, language use, and so forth, shifting from a Latinx-centered worldview to a White American worldview (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014; Capodilupo & Forsyth, 2014; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Félix-Ortiz, Newcomb, & Myers, 1994). However, the concept of acculturation has shifted towards a multicontextual model. As a multidimensional and multilinear process, acculturation encompasses individual adherence to both home culture values and those of their host culture and considers the complexity of context (i.e., geographical settings and life experiences) which influences personal development (Arredondo et al., 2014; Knight, Jacobson, Gonzales, Roose, & Saenz, 2009). Country of origin, sociopolitical status, and immigration history may also impact the acculturation process among Latinx groups (Abraído-Lanza, Armbrister, Flórez & Aguirre, 2006).

Focus on acculturative stress in the research of eating disorders appears to be growing in popularity. Acculturative stressors may be emotional, physical or psychological, and can impact both the individual and his or her family members in different ways. A study of 118 undergraduate women found significant relationships between acculturative stress, body dissatisfaction, and bulimic symptoms (Perez, Voelz, Pettit, & Joiner, 2002). In 2010, the results

from a study completed by Gordon, Castro, Sitnikov and Holm-Denoma found that, for Latinx women, higher acculturative stress was predictive of a greater drive for thinness. In 2016, Claudat, White, and Warren reported that Latinx and Asian American college women who endorsed higher levels of acculturative stress were more likely to experience negative self-esteem and increased eating pathology. These studies suggest a relationship between acculturative stress and body dissatisfaction, emphasizing the importance for the assessment of eating pathology and self-esteem for women who present to therapy describing feelings of acculturative pressure.

Help-Seeking

Early eating disorder research literature has continually commented on the reluctance of women of color to seek out mental health treatment. Articles devoted to the resistance of women of color to mental health treatment often describe this decision as a deliberate choice made by women of color to not disclose mental health concerns, particularly disordered eating, for fear of "selling out" by manifesting symptoms which are stereotypically White (Root, 1990). Language that reflects a blame-the-victim mentality is often used when discussing an underutilization of treatment services due to feelings of shame and stigmatization (Talleyrand, 2012).

In a recent study conducted by Higgins, Bulik, and Bardone-Cone in 2016, researchers looked at Latinx women who self-identified as having an eating disorder in comparison to those who did not, focusing on eating disorder pathology and mental health stigma. Despite both groups meeting criteria for an eating disorder history, only Latinx women who had less fear of being stigmatized for seeking mental health treatment endorsed an eating disorder history (2016). This research indicates that Latinx women may be less likely to endorse an eating disorder

history if they are fearful of the stigma that is associated with seeking out mental health treatment (2016).

However, this conceptualization of help-seeking in the research literature disregards the fact that strong distrust of the mental health system and fear that providers may not be able to help are worries that are founded in the unethical history of mental health research and treatment. In the past, psychological research has taken advantage of communities of color to demonstrate White superiority or use people of color as comparison groups for the enhancement of psychological theories that serve Whites. As Guthrie (2004) described in *Even the Rat was White*, psychologists in the late 1800s and early 1900s often demonstrated overlapping priorities: a quest for the measurement of dissimilarities and supporting eugenics. For instance, Lewis Terman, the Stanford psychologist known for revising the Binet scales in 1916, demonstrated his insular views when he stated, "(Mental retardation) represents the level of intelligence which is very, very common among Spanish-Indian and Mexican families of the Southwest and also many negroes. Their dullness seems to be racial… There is no possibility at present of convincing society that they should not be allowed to reproduce, although from a eugenic point of view they constitute a grave problem because of their unusually prolific breeding" (p. 61). According to Guthrie, Terman emphasized "blood lineage" to explain IQ scores. These sentiments were echoed by Eugenicists Karl Pearson, a founder of modern statistics, and Charles Spearman, the developer of the two-factor theory of intelligence. When considering "help-seeking" for individuals of color in light of the history of psychological research, it is understandable and protective that one may be wary of both research and treatment.

Moreover, individuals of color may be concerned by the lack of representation of their cultural background when entering into a therapy office. Indeed, in private practice settings, the

majority of therapists are White. The prevalence of White therapists is particularly apparent when looking for nationally recognized specialists for eating disorders (Talleyrand, 2012). With these considerations in mind, it is imperative that culturally sensitive outreach and recruitment for mental health services involve substantial commitment and time in order to build relationships with members of the community.

A recent qualitative study conducted by Reyes-Rodríguez, Davis, Patrice, and Bulik in 2013 illustrates the specific barriers for Latinx women in seeking out mental health treatment for eating disorders. This study utilized grounded theory to complete in-depth interviews with five Latinx women with histories of eating disorders and five Latinx mental health providers. Emotional barriers that patients endorsed around reluctance to engage in help-seeking behaviors included stigma regarding mental health treatment, fear of not being understood, family privacy, and not being ready to change (2013). Clients also described a lack of information surrounding eating disorders and a lack of bilingual treatment (2013).

Non-fluency in English is often a significant barrier in Latinx access to appropriate mental health resources (Arredondo et al., 2014). The lack of adequately trained bicultural and bilingual health workers appears to lead to a lack of sensitivity to Latinx mental health issues and ineffective treatments (2014; Tucker, Ferdinand, Mirsu-Paun, Herman, Delgado-Romero, van den Berg, & Jones, 2007). Lastly, access issues, including “lack of physical access to services (i.e. a lack of reliable transportation), affordability, a lack of awareness of treatment options, and a lack of bicultural and bilingual health care providers and supportive staff,” are significant concerns in accessibility of physical and mental health treatment for Latinx clients (Arredondo et al., 2014, p. 107).

While Anorexia Nervosa is associated with high mortality rates, it is difficult for clients to access treatment due to its high costs. In a 2017 study, Guarda, Schreyer, Fischer, Hansen, Coughlin, Kaminsky, and Redgrave found that the average cost per day for an in-patient-partial-hospitalization program was $2,295 for in-patient and $1,567 for partial hospitalization. Residential treatment was found to be associated with higher costs and is also often seen as necessary for weight restoration. This financial burden for individuals with Anorexia Nervosa and their families is compounded by the fact that insurance companies may refuse payment for treatment. Moreover, if insurance companies are willing to pay a portion for treatment, reimbursement for families is often limited.

Misdiagnosis

As Capodilupo and Forsyth (2014) contended, since research of Anorexia Nervosa has focused solely on upper to middle class, White Women, the diagnostic criteria for Anorexia, unsurprisingly, has been founded on theories of extreme thinness, refusal to eat, and fear of gaining weight. With these criteria at the center of Anorexia Nervosa diagnoses, clinicians may fail to identify individuals whose symptoms deviate from traditional norms (Gilbert, 2003). Indeed, Western diagnostic tools do not consider religious, cultural, and beauty practices of non-Western groups. Therefore, women of color with eating disorders may be overlooked and even denied treatment based on their account of presenting concerns. Considering these factors, and the significant disparities in accessing health care treatment for eating disorders, women of color may not receive appropriate diagnoses and treatment for Anorexia Nervosa, and other disordered eating patterns. Clinicians must move beyond the established eating disorder diagnoses criteria, acknowledging that an idealization of the “thin ideal” may not always be present. It is imperative for clinicians to focus on assessing clients of color for maladaptive eating habits and concerns

with physical appearance as separate entities from the traditional Western emphasis on the thin ideal (Capodilupo & Forsyth, 2014).

Eating Disorder Treatment

Presently, Cognitive Behavioral Therapy (CBT) is considered the most effective treatment for eating disorders. However, there is a dearth of research surrounding the effectiveness of CBT for treating eating disorders in women and men of color (Palmer, 2007). Most research on the effectiveness of CBT has focused solely on White women or has made no acknowledgement or race and ethnicity of study participants (Gilbert, 2003). Palmer (2007) contended that clinicians should proceed cautiously when utilizing CBT with women of color for eating disorders, determining tentatively whether this treatment is ultimately beneficial for the specific needs of the client.

In 2016, Pereza, Ohrta, and Hoek reviewed the current use of evidence-based treatments for eating disorders among Latinx individuals in the United States. According to the review, Cognitive Behavioral Therapy for Bulimia Nervosa was recently adapted for Latinx clients in a self-help program for Mexican American women with Binge Eating disorders (Shea, Cachelin, Uribe, et al., 2012). Indeed, a recent adaptation of the core concepts of CBT included incorporation of the family into therapy. Since CBT has traditionally taken an individualist approach, the treatment adaptation included additional therapy sessions for the client and her spouse to focus on communication and parenting skills. "This resulted in the treatment reinforcing the strengths of the patient's collectivistic values and the patient feeling less alone in her recover process" (2016, p. 380). An additional adaptation included adjusting meal plans to encompass culturally important foods, as well as foods that were readily accessible and affordable. Indeed, food and eating often carry varying meanings depending on the client's

culture of origin. Food may play a specific role in regard to comfort, family bonding, and cultural identity for Latinx clients, with variation based on country of origin. The results of this study also indicated benefits for participants when the therapist discussed discrepant beauty ideals between the participant's culture of origin and American culture, as well as discrepant gender roles. Moreover, participants described the process of providing psychoeducation to immediate and extended family members as helpful for clients.

As clinicians and researchers continue to explore the most effective treatment for eating disorders, it is important to consider the unique cultural and contextual factors that may impact the presentation and treatment options for each individual client. Indeed, clinicians may need to adapt the CBT approach to include an exploration of cultural values in relation to how the client perceives his or her presenting concern (Talleyrand, 2012). Incorporation of non-traditional interventions and critical examination of traditional treatments, created for White individuals, will be necessary in determining the most culturally competent approach for client treatment (Palmer, 2007). However, clinicians will not be able to provide culturally competent treatment for eating disorders if researchers in the field do not commit to engaging in multicultural psychological research to study within-group differences for women of color with eating disorders (Gilbert, 2003; Hall et al., 2016).

When working with Latinx women who struggle with eating disorders, cultural considerations suggest that traditional Cognitive Behavioral Therapy, which emphasizes one-on-one talk therapy, may not be the most appropriate treatment. Considering the value those who identify as Latinx often place on family relationships, family therapy may be a culturally competent and effective form of treatment for Latinx clients presenting with eating disorders (Talleyrand, 2012). Indeed, family support has been described as a key component for eating

disorder treatment retention for clients who identify as Latinx (Reyes-Rodríguez et al., 2013). Non-traditional cultural interventions currently employed by culturally competent clinicians working with Latinx clients include the use of *Dichos*, proverbs and sayings that are relevant to Latinx culture (Zuniga, 1992). Using *La Receta*, or prescription, in therapy gives clients the opportunity to take something with them, such as homework, when ending the session (1992).

Familismo

Familismo, a Latinx cultural value of family of origin, involves family-centeredness, and loyalty to family, as well as an emphasis on interdependence (Arredondo et al. 2014). This may involve Latinx women's engagement with *familia* as central to identity and as an expression of dedication and commitment to family and family values. This natural concern for the well-being of one's family often mediates Latinx women's well-being. It is helpful for therapists to be mindful of the influence of *familia* on Latinx values; this inquisitiveness regarding the role of *familia* is important in understanding the family influence on the client (2014).

Marianismo

The concept of *marianismo* in Latinx culture emphasizes the role of women in the family. Early socialization experiences for Latinx girls emphasizes *cariño* (affection or care) and *marianismo*. Girls are often urged to display affection and emotion and are encouraged to take care of those around them (2014). According to the "Ten Commandments" of *marianismo*, women are to be self-sacrificing, submissive, and pure (M. R. Gil & Vázquez, 1996). Tenets of *marianismo* touch on the values of family, virtuosity and chastity, subordination to others, self-silencing, and spirituality (Castillo, López-Arenas, & Saldivar, 2010). While often connected with self-sacrificing and submissiveness, *marianismo* plays a significant role in family orientation (Arredondo et al., 2014). On the other hand, clinicians and researchers must not

assume that adherence to *marianismo* negatively impacts gender socialization and value prioritization for Latinx women; the experiences of *marianismo* may look different across Latinx cultures and by generation. Therapists and researchers must consider the ways in which *marianismo* may be influenced by acculturation of generational status.

However, as Arredondo et al. (2014) stated, "Counselors need to exercise caution and not assume that new-generation Latinas are less influenced by *familismo*, *respeto*, and *marianismo* than were their mothers and grandmothers" (p. 24). While these values may or may not be central to each client's cultural experiences, opening up conversations around the applicability of these values may assist clients in their recovery and healing.

Given the lack of research around Latinx clients and Anorexia treatment, it is imperative that researchers and practitioners shift focus to this phenomenon. Considering the history of the mental health field and the appropriate distrust of providers, researchers must explore the experience of Anorexia treatment, from help-seeking, diagnosis, and through therapy. Indeed, understanding the treatment process within the context of culture may fill gaps in the eating disorder literature, capture the unique experiences of Latinx clients, and add to the existing literature on the impact of intersecting identities in the development and treatment of eating disorders.

CHAPTER III

Methods and Procedures

Research Design

Qualitative methodology allows counseling psychology researchers "to explore the richness of the personal experience of our profession for both the counselor and the participants..." (Berrios & Lucca, 2006, p. 181). Not only does qualitative methodology enable researchers to uncover in-depth knowledge and understanding of participant experience, but it closely aligns with the values of counseling psychology (2006). Moreover, as a therapist with a feminist orientation, qualitative inquiry works in parallel to this theoretical approach, empowering participants to be experts of their own experience.

Approaches to the Data

As Vagle (2014) wrote, "phenomena are the ways in which we find ourselves being in relation to the world through our day-to-day living" (p. 20). Phenomenological research allows researchers to study how a phenomenon appears in the lifeworld (2014). Utilizing a phenomenological perspective enabled this researcher to explore what individuals experience in regard to the phenomenon of psychotherapy for treatment of Anorexia and how these individuals interpret those experiences. By engaging in in-depth interviews, phenomenology offers a perspective on the lived experiences of individuals who have experienced the phenomenon. As Adams and Van Manen (2008) contended, "The value of phenomenology is that it prioritizes and investigates how the human being experiences the world" (p. 616).

Phenomenology

The phenomenological idea of going to the things themselves means to describe phenomena as they are experienced. Edmund Husserl, a German philosopher, believed that a subject was meaningfully connected to everything else in the world. Therefore, Husserl believed that meaning making was the essence of human experience. Phenomenological research, at its roots, is the study of essences. As qualitative researchers, we are less interested in the facts of a particular instance or situation. On the contrary, phenomenology derives descriptions of individuals' experiences, learning how they understand and interpret their lived experiences and attempting to see phenomena as they are lived. Moreover, phenomenology emphasizes that one cannot separate the self from the world; we are woven into the world and must come to understand our experiences through this connection (Merleau-Ponty, 1968). "We are involved in the world and we do not succeed in extricating ourselves from it in order to achieve consciousness of the world" (1968, p. 5).

Reflective Lifeworld Research Approach

Understanding Latinx clients' perspectives of eating disorder treatment requires an ability to openly connect with their lifeworlds. This study, based on Dahlberg et al.'s Reflective Lifeworld Research approach, attempts an in-depth understanding of the experience of Anorexia Nervosa treatment, by creating space for the phenomenon to show itself (Dahlberg, Dahlberg, & Nyström, 2008). Through the Reflective Lifeworld Research approach, participants' lived experiences and perspectives are seen as the priority.

Dahlberg et al.'s (2008) work emphasizes an attitude of openness towards the phenomenon in focus; this concept encompasses not only openness to participant experiences and the essence of the phenomena but includes openness to oneself as the researcher as well.

Through this openness, the researcher demonstrates a willingness to be sensitive to the complexity of the lifeworld and all of the phenomenon's aspects, without developing a prior hypothesis to explain it. Indeed, the researcher does not make assumptions of understandings of meaning; all meanings are understood as contextual, infinite, and expanding (Merleau-Ponty, 1995). Therefore, immediacy is necessary in order to truly see aspects of the phenomenon.

Researchers must also be open to understanding the research process context (Dahlberg et al., 2008). From the research question, the data gathering methods, to the analysis, the phenomenon must be understood in context. As researchers describe or interpret the phenomenon, the understanding of the phenomenon will be contextualized. As Vagle (2014) stated, "the contextual aspects that surround those living the phenomenon will need to be illuminated and explored" (p. 62).

Through openness, the goal of the Reflective Lifeworld Research approach is to be aware of the instances in which the phenomenon presents itself in the research through the participant's lifeworld. As Dahlberg and Dahlberg (2003) wrote, "The lifeworld is the lived and experienced world and thus is something more than the world itself and more than the subject itself" (p. 36). Therefore, the lifeworld can be viewed as a world of meaning that can never be completely explored and described (Merleau-Ponty, 1995; Dahlberg et al., 2008). As events occur in the lifeworld, meaning emerges, and as the lifeworld changes, meanings change as well. The researcher must, therefore, remain constantly sensitive to the ambiguity of the lifeworld.

By studying the world as it is lived, the Reflective Lifeworld Research approach allows researchers to study a particular phenomenon and how it appears in the lifeworld. Interestingly, the researcher is not studying the individual. While a particular individual may be a participant of the study, they are not the unit of analysis. The individual may assist the researcher in gaining

access to the manifestations of the phenomenon, but the unit of analysis is not the individual; it is the phenomenon.

Essences

As Merleau-Ponty (1995) described, phenomenological research aims to study essences. "An essence is, simply, a phenomenon's style, its way of being, and thus the essence cannot be separated from the phenomenon that it is the essence of" (Dahlberg, 2006, p. 18). Researchers do not add essences to the research nor give them meaning. Essences are only discovered when the phenomenon presents itself (Dahlberg, 2006).

In rich interviews, essences can be found. However, it can be difficult to distinguish where one phenomenon ends and the other begins. As Merleau-Ponty (1968) described with his concept "flesh of the world," all phenomena and meaning are connected. However, by observing the phenomenon's essence, its core meaning, the researcher is able to view the essential structure of the phenomenon (Dahlberg, 2006).

Bridling

Not only can it be difficult to distinguish particular phenomenon from each other, but it can be difficult to separate ourselves from the phenomenon (Merleau-Ponty, 1968). After all, we are part of the world that we are investigating and studying. As Dahlberg (2006) stated, "As researchers… we are not these objectivistic scientists that distantly register meanings, as a widespread understanding of research says, but are immensely involved in the explication of meaning" (p. 16). By studying the assumptions that we have about the world, before, during, and after research, we can loosen our ties to our understanding to accurately see the phenomenon and its meaning.

Therefore, in order to be open to the phenomenon, researchers must “bridle” their understanding of the phenomenon and the phenomenon’s meaning. “Neither researchers nor anyone else can cut off one’s pre-understanding, that little vexation that constantly has occupied philosophers as well as researchers, but it can be ‘bridled’ from having an uncontrolled effect on the understanding” (Dahlberg, 2006, p. 128). By carefully scrutinizing one’s pre-understanding of the phenomena, the researcher attempts to not let these notions overshadow the phenomenon’s presentation of meaning.

As such, bridling involves setting these pre-understandings aside so that they do not thwart the researcher’s commitment to openness. This process does not simply occur at the beginning of the research project; instead, the researcher is continuously engaged in bridling throughout the process so that she or he remains open for the phenomenon and its meaning to show itself. By gaining some distance from the phenomenon, the researcher may be able to explore the true essence.

Bridling can only occur if researchers are able to take a reflective and open stance, realizing that one must “not attempt to make definite what is indefinite” (Dahlberg & Dahlberg, 2003, p. 45). By being patient and attentive, the researcher questions, wonders, and reflects on their first thoughts surrounding the phenomenon, remaining open throughout the process. Vagle (2014) expressed concern regarding literature reviews that may compromise openness and “end up settling matters before the study was even conducted” (p. 72). However, a review of the literature can be beneficial for one to become familiar with the phenomenon, as long as it does not become a guide for what the phenomenon should be. By not creating a theory or hypothesis regarding the phenomenon, the researcher is able to be open to learning about “what it is to live in the world” (2016, p. 72).

Research Team

The research team for this study was comprised of three cis-gender females: The primary researcher, who identifies as a fourth-year White doctoral student in Counseling Psychology, a second-year Latinx doctoral student in Counseling Psychology and a second-year Latinx doctoral student in Counseling Psychology. All three researchers had previous training and experience conducting qualitative research. The primary researcher initially met with each member of the research team individually to reflect on their experiences and biases related to the phenomenon under study. Throughout the data analysis stage of the research process, researchers met biweekly to discuss initial meaning units and themes of meaning and, ultimately, reflect on essential meanings to shed light on the essences of the phenomenon.

Researchers' Positionalities

It was imperative, as researchers, to engage in self-reflection and bridling of positionalities related to the research project. This involved researchers' examining their own experiences with the phenomenon of interest, as well as pre-understandings, thoughts, reactions, and feelings. Prior to taking part in the reading of the first interview transcript, the researchers engaged in reflection on their own assumptions and experiences related to (a) Eating Disorders, both personally and/or professionally, (b) Understandings of traditional eating disorder treatment, (c) The way one's culture or background impacts the researcher's understanding of eating disorders and eating disorder treatment. Below is a summary of each research team member's pre-understandings prior to data analysis:

Primary Researcher's Positionality

I am a 29-year-old, White American cis-gender female doctoral candidate in Counseling Psychology at the University of Georgia. I am both professionally and personally invested in the

experiences of Latinx females in eating disorder treatment. More specifically, I initially became introduced to this phenomenon after recognizing that a close friend who identifies as Latina had been struggling with Anorexia throughout our friendship. I also have experienced my own concerns regarding disordered eating, body shaming, and difficulties with my body image.

In the past few years, as a member of the ¡BIEN! research team at the University of Georgia, I have had the opportunity to engage in local service and outreach events with Latinx communities in the Athens area. My eyes have been opened to the extraordinary barriers to mental health treatment in these communities. Helping at the Athens Latino Center for Education and Services (ALCES), I gained awareness of the unending hurdles that stand in the way of treatment, from lack of bilingual services, few sliding scale options, transportation concerns, immigration status, and many more. Additionally, through my coursework and readings, I have learned a history of treatment which has used mental health to oppress and discriminate against people of color.

Assisting on a research team with Dr. Anneliese Singh, studying the experiences of psychotherapy for women of color survivors of child maltreatment, I listened to participants whose cultural experiences had been dismissed, invalidated and ignored in treatment. Participants spoke of therapists not recognizing their intersecting identities, making no mention of client and therapist cultural differences, and ignoring client concerns around discrimination and oppression. Each voice spoke of discrimination in the therapy room. At a time when cultural competence is a buzz word in the field of psychology, complete lack of cultural considerations in treatment was pervasive in these participants' stories.

After being a part of Dr. Singh's research team, I read about traditional eating disorder treatment methods and began to wonder if these approaches were recognizing and incorporating

the intersecting identities of clients into therapy. When I turned to the literature, I expected there to be limited scholarly articles published on understanding Anorexia treatment for Latinx clients. However, what I found was absolutely no research on this topic. It was as if this phenomenon did not exist in the world of eating disorder treatment.

While recognizing that research needed to be completed on the experiences of Anorexia treatment for Latinx clients, I was reluctant to pursue this topic because of my identity as a White woman. I could never truly understand the experiences of the participants I would interview. With the immense amount of privilege that I hold, I am similar in many ways to the White, female clinicians Latinx clients are likely to work with in eating disorder treatment. Would they believe I would be different? Would participants be willing to open up to me, a White woman? Given what I had learned about mental health and mental health treatment through clinical work, research, and study, I honestly would understand if a participant was not willing to participate or disclose personal information based on their appropriate distrust around my identities.

As I reflected on if I should pursue this research topic, I decided to use a class opportunity as a semi-pilot for the project. I interviewed three eating disorder specialists about their understandings regarding how culture may or may not be included in eating disorder treatment for Latinx clients. After these interviews, I was struck and discouraged by the mixed responses on the importance of incorporating discussions of culture into Anorexia treatment. I realized that this research needed to be out there. I hoped that my genuine passion for this topic and willingness to grow, to learn, and to be open, would help me create research *with* my participants that would evoke change. I did not know what that change would look like, but I wanted something: maybe a reaction, a realization, or an “ah-ha” moment that Latinx clients battling Anorexia are out there. They are not an anomaly. Their voices matter.

Researcher 2's Positionality

My bicultural family life gave me so many rich experiences and lessons but also sent many mixed messages. From a young age until about 20-years-old, I was considered very skinny by my family. What I remember most is that the Cuban side of my family commented on how skinny I was and pressured me to eat more and more, though I would say I was full. However, around the age of 20, I began going through a deep depression where I stopped exercising, ate more, and ultimately gained a good amount of weight. Although I was in no way overweight, my Cuban side of my family immediately commented on my eating patterns, choices, exercise, and body, yet they still wanted me to eat in the same ways I had growing up. This mixed message of being called the Latinx term of endearment (in their regard) of *gordita* and also feeling pressure to eat a lot because it showed my appreciation for my family who cooked was extremely confusing.

On the flip side of this experience, I have recently lost a bit of weight because of stress from graduate school and my family now says I do not need to be any skinnier and I should eat more. Before reading these interviews, my experience with food, family, culture, and body image were quite confusing. To add to this mix, I was a Latina woman who played collegiate soccer, which is so rare in Latinx communities. My White, male coach told me I needed to gain muscle, but my grandmother would tell me to be careful not to get bigger thighs. Honestly, my understanding of living in two cultures and receiving multiples messages about food, health, body image, and fitness from each culture gave me significant distress when trying to understand my identity.

When Amelia was looking for help for her qualitative studies with Latina women who had eating disorders or had been in treatment for eating disorders, I was immediately interested.

The research questions Amelia was hoping to have answered were questions I had asked myself in a household with a Latina mother and White father.

Researcher 3's Positionality

I am a 26-year-old Latina living in the United States. I am a second-year doctoral student. I am a first-generation college student that is able bodied, and low income. These identities might affect my perception of eating disorder treatment because treatment is expensive, and I might be inclined to relate if participants share some of my similar identities. This includes my biases that mainly White women can afford treatment which is not always true or the case.

My perceptions of eating disorders are not very extensive, but I would often see it on television and it was depicted as happening to mostly White women. I saw one or two brief television shows that displayed Latinas and eating disorders, but this was on Spanish speaking television and it mostly depicted lighter skin Latinas.

Growing up, there were body images issues but none of my friends or people close to me experienced them. I do not have very much knowledge about the topic beyond workshops and a few scholarly articles that I have read. In my experience, it is difficult to find practitioners that are culturally competent in general. I have struggled to find practitioners that are culturally competent and fully understand the cultural dynamics. I have not experienced any significant mental health issues or eating disorders in my life. I am aware of the ways mental health issues can manifest themselves physically.

All three researchers shared the following assumptions:

- Anorexia Nervosa is an illness that affects individuals of all genders, races, ethnicities, and backgrounds.

- Experiences of Latinx clients in Anorexia Nervosa treatment are important; these stories need to be heard, acknowledged, and discussed by eating disorder specialists and in Latinx communities.
- Cultural competency is a lifelong pursuit that is never-ending and constantly changing.

Procedures and Participants

Description of the Sample

Purposive and intensity sampling were used to recruit seven participants. Paper and electronic flyers were circulated about the study on listservs for professional psychology and counseling associations, such as the American Psychological Association, Division 17, Division 35, and the National Latinx Psychological Association. Due to the challenges of recruitment, the following section will be written by the primary researcher in the first person, in order to capture the experience of recruitment.

After contacting psychology and counseling associations, approximately 500 e-mails were sent to eating disorder specialists across the country. I began by e-mailing eating disorder specialists in Georgia and North Carolina, hoping that my ties to the Universities in these states would offer some form of connection. Next, I e-mailed major eating disorder treatment centers across the country. When I received little response from these potential recruitment sources, I realized that it could be more helpful to e-mail eating disorder treatment specialists in areas where there are higher populations of Latinx individuals. I e-mailed all of the eating disorder specialists that I could find in the top 50 cities with the largest Latinx populations. I received many thoughtful messages, with the same basic message: “All of my eating disorder patients are White,” or “I’ve never worked with a Latinx person in Anorexia treatment.” From October to February, I sent approximately 30 to 50 e-mails each week.

I realized that I was running out of time. On one hand, I recognized that I had to complete a dissertation before I could graduate. On the other hand, the difficulty finding eating disorder specialists who had worked with Latinx clients made the topic feel all the more important. My frustration fanned the flame of passion I had for this topic. If I was having this much trouble finding providers, how were clients able to do so?

At the end of February, I met with my co-chairs and discussed other dissertation topics to pursue. I made a pact with my advisor that I would only attempt recruitment for one more month, and then I would be willing to change the topic. In these weeks, I sent e-mails to college counseling centers at Hispanic Serving Institutions and sent messages to executive members of Lambda Theta Alpha (a national Latinx sorority) chapters across the country. In March, one of the researchers on my team posted about the study on her sorority's Facebook page. The first two participants were interviewed in March and had reached out to me because of this posting. I began to follow activists on Instagram promoting body positivity in the Latinx community and connected with the third participant who is an active proponent for body positivity in her community. After the founder of Nalgona Positivity Pride reposted a description of my study to her Instagram page, I was e-mailed by the fourth participant. I connected with the fifth participant after e-mailing her about an online article she had written for the National Association of Anorexia Nervosa and Associated Disorders (ANAD). Lastly, I e-mailed a clinician, actively involved with ANAD, who was willing to post a description of the study on her Facebook page. The final two participants reached out to me after reading about the study on this clinician's social media account.

Participant criteria include: (a) identification as Latinx and female, over age 18, (b) diagnosis of Anorexia Nervosa, self-identified as in recovery, (c) English speaking or bilingual

and (d) having attended therapy services specifically for the treatment of Anorexia Nervosa. Therapy services must have been provided in English. As participants contacted the researcher, screenings were conducted to ensure that the above inclusion criteria were satisfied. No potential participants were screened out from the study. When participant criteria were met, informed consent procedures were explained and an hour to an hour and half phone interview was scheduled. Participants were asked to select a pseudonym, in order to protect confidentiality, and were asked to compete the demographic form prior to the interview. This researcher referred to the participant by their pseudonym throughout the entire research process. During the phone interview, ongoing informed consent was used, and participants were reminded that they could decide to skip questions or end the interview, whenever they decided to. None of the participants chose to skip questions or terminate the interview early.

At the end of the interviewers, participants were asked if they would mind receiving an e-mail from this researcher following up with them the next day. Each participant received an e-mail expressing the primary researcher's appreciation, asking how the participant was, and seeing if they needed anything from the primary researcher. Qualitative research scholars suggest that researchers provide a list of referrals for counseling professionals in the participant's areas rather than providing interventions during the interview (Draucker, Martsolf, & Poole, 2009). Additional resources or information regarding counseling services were not requested by any of the participants after the interview.

Participants included seven participants, all of whom identified as Latina or Latinx. Six of the participants had been diagnosed with Anorexia Nervosa. One participant stated that she did not meet the criteria for Anorexia, but that her symptoms involved restricting. After consulting with this researcher's co-chair, we concurred that inclusion of this participant was

appropriate. Six of the participants identified as female, with one participant describing their gender identity as agender. This participant stated that their preferred pronouns are *they*, *them*, and *their*. All participants self-reported attending eating disorder treatment, in English, for Anorexia Nervosa, or Other Specified Feeding and Eating Disorder with symptoms of restriction. Moreover, all seven participants self-reported being in recovery from Anorexia Nervosa. The participants' ages ranged from 22 years to 36 years, with an average age of 27.2. Self-reported demographic information is provided in Table 1.

Table 1

Participant Demographics

Pseudonym	*Gender*	*Age*	*Race*	*Ethnicity*	*Country of Origin*	*Generation in US*
Star	Female	26	Latinx	Mexican American	US	First
Angela	Female	23	White	Latina	US	First
Melinda	Female	26	Not Listed	Latina	US [Colombia]	Second
Allie	Female	26	Biracial Latina	Mexican, White	US	Second
Ani	Agender	22	White	Mexican, European	US	Third
Maria	Female	36	White	Hispanic	US [Nicaragua]	First
Margarita	Female	32	Multicultural	Latin American	Mexico	First

Pseudonym	*Religious Affiliation*	*SES*	*Education*	*Location of Residence in US*	*Length in Treatment*	*Age of Diagnosis*
Star	Catholic, Practicing	Lower-Middle	Bachelor's	Northeast	1.5 Years	20
Angela	None	Middle	Master's	Midwest	4 Years	19
Melinda	Catholic, Not Practicing	Middle	Master's	Southeast	N/A	N/A
Allie	Christian, Practicing	Lower-Middle	Bachelor's	Midwest	3 Years	23
Ani	None	Lower	High School	Northwest	6 Months	20
Maria	Catholic, Practicing	Middle-Lower Middle	Master's	Southeast	4 Months Inpatient / 10 Years Outpatient	26
Margarita	Agnostic [Raised Catholic]	Middle	Master's	Western	~4 Years	14 or 15

Study Instruments

The instruments used in this study included the researchers themselves, a demographic form, and the semi-structured interview protocol.

Demographic Questionnaire

Each participant completed a brief demographic questionnaire via e-mail that included questions about the participant's age, race/ethnicity, gender identity, education level, sexual orientation, marital status, religious affiliation, country of origin, generation in the United States, socioeconomic status, education level, city of residence, age of Anorexia Nervosa diagnosis, and the length of time in treatment for Anorexia Nervosa. Participants also provided the pseudonym they wished to be referred to throughout the interview. A copy of the demographic questionnaire is provided in Appendix A.

Semi-Structured Interview

Each participant completed one semi-structured interview with the primary researcher ranging in length from 42 minutes to 110 minutes (mean = 77 minutes). Phenomenological interviews conducted in a semi-structured format with open-ended questions focus on the lived experiences of eating disorder treatment (Vagle, 2014). Consistent with the Reflective Lifeworld Research approach, the interviews aimed for rich interactions between the interviewer and interviewee in order for the participant to share their experiences of the phenomenon. Interview questions were developed based on the literature on the treatment of Anorexia Nervosa for women of color. Questions explored how participants experienced treatment, as well as the ways in which cultural considerations may or may not have been incorporated into treatment.

Interviews were approached with openness and hopefulness that the phenomenon and its essence could be presented. As Dahlberg et al. (2008) suggested, the primary researcher

approached the interviews with an intent to listen and try to understand the phenomenon within its context. Each interview was not only viewed as a valuable opportunity to learn more about the phenomenon, but as a conversation that would truly honor the words of the participants. The primary researcher strived to be supportive and present-focused throughout the interviews.

While the semi-structured interview provided a guideline for the dialogue, the primary researcher was intentional in focusing on the phenomenon of interest. When conversation drifted to the experience of Anorexia Nervosa, the interviewer gently steered the conversation back to experiences specifically in treatment. Indeed, based on Vagle's (2014) suggestion, the interviewer was attentive to initial assumptions she had about what the participant meant. In several interviews, the interviewer followed Vagle by asking, "I have an understanding of that phrase you just used, but can you tell me what it means to you?" (Vagle, 2014, p. 81). Any assumptions of meaning were opened up through further questioning with phrases such as "tell me more about that" (2014). Through this combination of structure and openness, the primary researcher sought to create a space to learn as much about the phenomenon as possible.

Importantly, all interviews were completed in English. Since one criterion for participation was participating in treatment in English, it was assumed that participants would typically feel comfortable completing study interviews in English as well. This specification of participants having completed treatment in English is important to note; individuals who may have completed Anorexia Nervosa treatment solely in Spanish might have had a different cultural experience than Latinx clients completing treatment in English. On the other hand, if participants stated that they would feel more comfortable discussing certain aspects of the study in Spanish, a bilingual member of the research team was available. It was imperative to this research team that the participant feel as comfortable as possible when discussing experiences in

treatment. All participants opted to complete the entirety of their interviews in English. A copy of the semi-structured interview protocol is provided in Appendix B.

Data Gathering and Analysis

An information packet was sent to each potential participant as they expressed interest in completing an interview. This packet included a copy of the recruitment flyer, a copy of the demographic questionnaire, a copy of the consent form, and a list of potential interview concepts. If potential participants stated that they were still interested in participating, they were screened by the primary researcher to ensure that the inclusion criteria were satisfied, and the consent form was asked to be returned. The participant then returned the signed consent form and the demographic questionnaire electronically.

All seven interviews were conducted over the phone and were audio-recorded. To ensure confidentiality, all participants were referred to by the pseudonym that they chose on their demographic form throughout the entire interview. Before beginning the interview, the primary researcher discussed informed consent and answered any questions. The researcher then introduced the study, explained her own identities, and her interest in the research study. The researcher's discussion of her identities at the beginning of the interview began when conducting the second interview. At the end of the first interview, when this researcher stated that she identifies as White, the research team members noticed a brief shift in the conversation with the participant appearing to reassure this researcher that the race and ethnicity of the therapist was not as important as who the person is. After this interview, and subsequent discussions with the research team, the primary researcher found it important to disclose her identity as a White cis-gender female at the beginning of the interview. The day after the interviews, participants were

e-mailed to see if they needed anything from this primary researcher or if counseling resources in their area could be provided.

Analysis

According to Dahlberg's Reflective Lifeworld Research approach, analysis means, at times, breaking up, organizing, and simplifying information (2008). However, this process is completed in the context of the whole. As Dahlberg et al. (2008) stated, "Lifeworld analysis could thus be understood as a synthesis, the way that the different parts, the meanings, particularities, and uniqueness are related to each other and to the whole of the research" (p. 233). There are parallels between this understanding by Dahlberg and the whole-part-whole process described by Vagle (2014). Both emphasize thinking about moments and meanings in relation the whole. We cannot understand the moments without considering the boarder context. The following phases of analysis will be discussed: transcribing, reflective journaling and bridling, a whole-part-whole analysis, auditing, and member-checking.

Transcribing

In order to look at both the whole at the parts, Dahlberg suggested first transcribing. All audio-recorded interviews were carefully transcribed verbatim by the primary researcher. Six of the interviews were transcribed within 24-hours of the interview in order to ensure accuracy. As Dahlberg et al. (2008) recommended, non-verbal information, such as pausing, crying, laughing, and sighing were all included in the interview transcripts. Listening to the interviews, the primary researcher jotted down any notes about thoughts or feelings she had throughout the interview.

Reflective Journaling & Bridling

Hand-written notes and journals were also transcribed and kept in a document called "Reflective Journaling." All three researchers bridled their personal experiences, biases and assumptions about the phenomena to ensure that pre-understandings of the phenomena did not limit openness. Team members were encouraged to journal about their reflections before data collection, before and after reading each interview, when thoughts arose throughout the process, after team meetings, and so on. Bridling is involved in all aspect of research, from pre-understandings to beginning the research investigation, and carries forward to readings, discussions, interviews, and analysis. Indeed, team members were intentional about discussing their understandings, interpretations and reactions to the data during research team meetings and in informal discussions. By thoroughly reflecting on their own biases and reactions, team members were able to examine and give voice to their understandings and interpretations of the data (Starks & Trinidad, 2007).

Whole-Parts-Whole

As Dahlberg (2006) noted, "when analyzing a text for meaning, it is imperative that each part is understood in terms of the whole, but also that the whole is understood in terms of its parts" (p. 236). All three team members individually engaged in a holistic reading of each transcript text to get a sense of the whole. This was followed by a line-by-line reading, follow-up questions, a second-line-by-line reading and subsequent readings (Vagle, 2014). By reading the entire text a number of times, researchers became more familiar with the sense of the whole, approaching with curiosity instead of trying to confirm what they thought would be there (Dahlberg, 2006).

Phenomenological Parts

After researchers have a thorough understanding of the whole, they can begin to turn to the parts. As stated above, the subsequent readings are focused on the smaller segments, also known as meaning units. For each page of the interview transcript, a segment was left blank for each member of the team to comment on the meaning of each unit of text pertaining to the phenomenon. As Dahlberg (2003) suggested, “this space is used for noting the emerging meanings and thoughts that come while trying to identify, unpack, and understand the meanings” (p. 243). By studying each individual transcript, each member of the research team was able to discern relevant words or phrases from the text that represent meaning (Wertz, Charmaz, McMullen, Josselson, Anderson, & McSpadden, 2011).

After completing this process of data analysis for the first two interviews, team members attended a team debriefing meeting to discuss impressions and come to consensus around meaning units and preliminary themes in the data. This process occurred again after the fourth interview and once more after the last interview. Peer debriefing allowed researchers to question biases and perceptions and also examine preliminary categories, reaching group consensus on understandings of the data. Before, during, and after these meetings, the primary researcher documented team members’ reactions and thoughts, emerging impressions of what the data meant, the relationship between themes, and how these reflections and engagements with the data could shape understanding (Starks & Trinidad, 2007).

Next, meaning units were clustered to help the researchers determine the essential meanings of the phenomenon. “To make clusters means to put together meanings that seem to belong to each other” (Dahlberg, 2006, p. 244). After meanings had been noted and clustered, the researchers returned to the whole. This involved understanding the phenomenon’s essential

meanings in relation to each other, as well as describing the phenomenon's essence. As the meanings and essences of the phenomenon were developed, team members engaged in in-person meetings and shared themes and understandings electronically.

Seven participants' interviews were transcribed, reflected upon, and analyzed through this process. While the concept of data saturation does not exist under the Reflective Lifeworld Research approach, since phenomena are indefinite, Dahlberg et al. suggested that five interviews is an appropriate starting place, if the phenomenon is not overly complicated (2008). Due to the richness and depth of each of the seven interviews, seven was determined to be an appropriate number of participants. All meaning units, themes of meaning, and preliminary essences of the phenomenon were reviewed by an external auditor, to check and verify the team's analysis, and then revised by the primary researcher (Vagle, 2014).

Participants were then e-mailed a copy of the themes, as well as visual representations of the essences of the phenomenon, for member checking. Member-checking was viewed as an important piece of the process to verify that participants' experiences and voices were accurately represented (Hays & Singh, 2012; Smart et al., 2011). Four participants provided positive feedback on the themes of meaning and the essences of the phenomenon. Three participants did not respond to this researcher's invitation to provide feedback. Three participants who responded expressed their excitement at the accuracy of the findings, their realization that they were not alone in their experiences, and their excitement to read the completed manuscript. One of the participants who responded clarified the context of some of her quotes, reminding this researcher to be wary of pulling participant words as meaning units without context. The research team looked at all parts of the analytic process, from transcripts, meaning units and reflective

journaling to determine themes of meaning, articulate the structure of meanings, and establish two main essences of the phenomenon.

All in all, Dahlberg et al.'s (2008) Reflective Lifeworld Research was used throughout the entirety of the research process, from first reflecting on the phenomenon in question, to developing the research questions and interview protocol, through the final analysis process. By emphasizing bridling assumptions around the phenomenon, Dahlberg et al.'s approach provided a way to explore the phenomenon with openness and reflexivity. Importantly, qualitative research methods have been suggested by Delgado-Romero, Singh, and De Los Santos (in press) to be, firstly, culturally compatible for Latinx culture and, secondly, effective in eliciting lived realities for Latinx groups. By approaching the phenomenon qualitatively, this research intended to prioritize cultural experiences and the complexities of Latinx clients' perspectives of Anorexia treatment.

CHAPTER IV

RESULTS

Introduction

The following chapter presents the findings from interviews with a sample of participants (n = 7), six of whom identified as female and one who identified as agender. All participants identified as Latinx. Six of the participants had received a diagnosis of Anorexia Nervosa; one participant explained that they did not meet the criteria for an Anorexia diagnosis, but their symptoms included restriction. All participants worked with an eating disorder specialist in treatment for Anorexia Nervosa and restriction. Importantly, all participants self-identified as being in recovery for Anorexia Nervosa and restriction. The purpose of this study was to explore the phenomenon of Anorexia Nervosa treatment for participants who identify as Latinx. Specifically, this study sought to explore how cultural considerations may or may not have been included in Anorexia treatment. The research questions for the study included:

1. What are the cultural experiences of Latinx clients in eating disorder treatment for Anorexia Nervosa?
2. What perceptions do Latinx clients have regarding the cultural competence of therapists for the treatment of Anorexia Nervosa?
3. In what ways, if any, do Latinx clients believe cultural factors played a role in engaging in treatment for Anorexia Nervosa?

Semi-structured interviews were conducted with each participant (Appendix B). Broad and open-ended questions were intentionally used to connect with participants' lifeworlds and allow for

inductive analysis. The inductive process involved noticing times in which the phenomenon emerged in ways that were both expected and unexpected based on the sparse literature on this topic. As Galman (2013) stated, the inductive process uses the data itself to create theories or form ideas.

Demographic information of the participants was collected and is described in Table 1. The interviews lasted between 42 minutes and 110 minutes and concluded when the participant stated that they did not have anything more to share about their experiences of treatment for Anorexia Nervosa. All of the interviews were completed over telephone between March 2018 and June 2018. All interviews were completed, and audio recorded, by the primary researcher. Each interview was transcribed by the primary researcher and reviewed by the primary researcher for accuracy. Participants were all e-mailed a copy of the themes for member checking to verify that participants' experiences and voices were accurately represented (Hays & Singh, 2012; Smart et al., 2011). Participants were asked to respond with feedback and edits were made based on participants' perceptions of the findings.

A phenomenological perspective was utilized for this project. Based on a Reflective Lifeworld Research approach, this study attempted an in-depth understanding of the experience of Anorexia Nervosa treatment, with the goal to "discover, analyze, clarify, understand, and describe meaning" (Dahlberg et al., 2008, p. 96). Participants' lived experiences and perspectives were seen as the priority. Considering the limited research exploring the phenomenon of Anorexia treatment for Latinx clients, Reflective Lifeworld Research was chosen based on the open and exploratory nature of this approach.

Dahlberg's Reflective Lifeworld Research approach dictates uncovering meaning units, grouping these units into clusters of meaning, and determining what clustered meanings relate to

each other in order to establish themes of meaning that capture the essence of the phenomenon (2008). Two essences of the phenomenon, also known as “essential meanings,” emerged from intentional analysis of meaning units and clustered meanings (2008, p. 245). Under each of the two phenomenological essences, individual lived meanings are included as well, and are expressed in the voices of the participant, in order to provide illustrations of concrete instances of the essence. The names of treatment facilities and providers have been changed to protect participant confidentiality. Table 2 provides a summary of the results of two essences of the phenomenon, as well as themes of meaning that form a pattern that describes the phenomenon.

Table 2

Summary of Essences and Themes of Meaning

Essence 1: Not Meeting Expectations / Not Fitting In "Isolation"	
Feeling Disconnected from Mental Health Providers [Power and Privilege in a White Dominated Field]	
Power	
"I was kind of afraid to bring it up"	Power differential in the therapeutic relationship / Belief in therapist expertise
Barrier to Access Treatment	
"I couldn't afford it"	Finances as barrier to access treatment / Lack of attention by clinicians to financial barriers
"They had money coming out of their pockets"	Awareness of economic disparities between client and White clients
"There was… almost nobody"	Distance as barrier to access treatment
Belief of Immunity from EDs for Latinx Clients / Failure to identify AN based on White norms	
"I never realized why she was weighing me"	Not informed about what treatment would look like / Distrust of treatment
"Give it a week and then you're done"	Urgency of seeking treatment / Health concerns (*See: Difficulty obtaining diagnosis)*
"I actually had a really hard time obtaining any kind of diagnosis"	Difficulty obtaining diagnosis (Late diagnosis, misdiagnosis) (*See: Not presenting as AN stereotype*)
"Anxiety and disordered eating… interchange a lot for me"	Comorbidities with Anorexia
Appropriate Distrust	
"We don't want you to go there anymore"	Family not approving of attending therapy / Expressing resistance to ED treatment because of worry White people would not understand
"I think it's almost… this expectation of what it was going to look like"	Discrimination outside session impacting distrust of White therapist / Worry of client regarding lack of understanding from White therapist
Only Latinx Client	
"Whenever I would bring something about culture or background… there wasn't… a mutual understanding of that"	Lack of cultural awareness in group therapy / Only Latinx member of group (Isolation / Exotified in treatment / Group resistant to discussing oppression that did not impact White people)

Difficulty Finding Latinx Therapist

"I didn't feel like I had been able to find a fit"	Difficulty finding Latinx therapist for ED / All White cis-gender female therapists
"I tried really hard to find a therapist at the time who spoke Spanish"	Difficulty finding Spanish-speaking therapist / Unwillingness to provide materials in Spanish for ED
"I'm never going to find this again"	Negative comparison of White therapist to Latinx therapist

Lack of or Incompetent Family Therapy

"My family was never involved"	Family not included in treatment / Therapist unaware of importance of including family in treatment
"I don't think this woman worked with a lot of Hispanics"	Lack of cultural considerations / discrimination in family therapy
"They said I wasn't advocating for myself"	White therapist blaming client / family for not meeting expectations in treatment

Lack of Cultural Awareness from White Therapists

Lack of Responsiveness to Cultural Factors

"Here's your meal plan"	Feeling that therapist only addressed part of the problem
"She just couldn't comprehend"	Not understanding, relating / Having to explain culture
"Oh, like, that's very common in Latino people"	Stereotyping and generalizing / Microaggressing

Cultural Values

Family & Connectedness

"In Latino culture, there's a Responsibility of taking care of your elderly"	Lack of understanding regarding family roles
"It's really rude to turn down food"	Lack of understanding regarding respect and expectations around food in the family
"She would dismiss a lot of my experiences"	Client feeling as though White therapist dismissed / invalidated her experiences with family
"What is your relationship with your parents?"	Discussions in individual therapy with White therapist about relationships with family members / Lack of focus on systems (*See: Lack of or incompetent family therapy)*
"I expected her to… be really Involved emotionally"	Lack of emotional involvement and connection with White therapist

Food	
"I wouldn't eat Mexican food because for me it was, like, really bad and calorically dense or whatever and I had a couple of dieticians that were like, "Oh, well, that food is, like, bad for you"	Encouraging distance from cultural foods
Language	
"I sent them an e-mail requesting that I could have materials in Spanish to send to them. To explain and they didn't have any. And they were just, like, "We don't… we can't... we don't have that. We've never had to deal with that."	Lack of materials in Spanish for family
Discrimination / Oppression	
"And she would go really quiet, and she would stare at the coffee table in front of me and, like, not talk."	Therapist unwillingness to discuss discrimination and racism (and how this contributed to eating disorder) / Invalidating client's experiences
"If anything, it was just another place where I felt like the other person."	Feeling othered in therapy (Discrimination outside replicated in therapy)
"There was something about their nonverbal cues that gave me the understanding that they still didn't get it"	Client observing therapist and group nonverbals
Lack of "Existence" of AN	
"I need your guidance"	Feeling undirected by therapist / Symptoms becoming worse with therapy (*See: Not informed about what treatment would look like*)
Feeling Disconnected from Latinx Culture	
Identities	
Not Belonging Anywhere / In-Between	
"I had lost all of my identity"	Feeling disconnected from cultural identities / Acculturation (Acculturative Stress)
"I'm mindful that when I tell this story, I very much look like the stereotype"	"Light-Skinned," White-Presenting
"I was definitely curvier"	Not presenting as AN stereotype / Institutionalized racism

Values

Language

"That… shows how not a part of our world it is"	Disconnection from the word "Anorexia"

Food

"I'm away from my family, away from my culture, and then even stepping away from food, which is another piece of my culture, it was even more isolating"	Feeling disconnected from cultural foods

Family

"How dare they let me go through this alone?"	Feelings of isolation from family / Conflict between treatment and receiving support from family

Barriers to Involvement / Privilege of Family Therapy

"She's not coming"	Awareness of family involvement between client and White clients

External Barriers to Involvement

"And I think it would have also been really helpful, obviously, if my parents were local but, unfortunately, they weren't so they couldn't see me at all"	Distance
"Because my mom had to take care of my siblings."	Family responsibilities
"I just didn't want to be a burden on my family when I knew that they already had other financial obligations"	Financial obligations
"I tried to explain to her, like, how… immigration status, like my mom is undocumented… She just couldn't comprehend… why she wasn't there"	Immigration status

Internal Barriers to Involvement

"She thinks that any problem that you have should be prayed about"	Preference for Religion
"They didn't want to admit that it was a real problem"	Fear & Denial

Stigma	
Stigma around mental health	
"And to accept that I had a mental illness meant that I was being weak"	Stigma around mental health / mental illness for Latinx families and clients
EDs not talked about in Latinx communities	
"Eating disorders are just not… talked About in the Latino community"	Eating disorders not talked about in Latinx community / Viewed as normal
"That stuff didn't exist"	Family not informed about eating disorders / Not understanding meaning of diagnosis
Costs of Culturally Incompetent Anorexia Treatment	
Early Termination	
"I'm not going to go back"	Early termination of services with therapist / Resistance to treatment
Assimilation to White Culture to Fit In	
"I'm just continuing being White"	Assimilation
Undertaking Recovery Process Independently	
"I think it would have taken me less time to get to a place of feeling at peace with my body and with food"	Having to undertake recovery process independently / Belief that process would have taken less time
Essence 2: Cultural Competence	
Therapist Intersecting Identities	
Latinx Therapist	
"And so, they gave me a Latina psychologist and it was great"	Switching to working with Latinx Psychologist / Access and availability to switch
Latinx Therapist Understanding Latinx Culture (Values & Discrimination)	
"She would talk to my mom in Spanish"	Latinx therapist could communicate bilingually with parent
"Mama comes from somewhere different"	Latinx therapist understanding / normalizing of parents' perspective
"They just go hard on you"	Discussions with Latinx therapist about roles / expectations in the family
"I had to cut a lot of people off"	Working in therapy with Latinx clinician to establish boundaries in familial relationships / Navigating self-care and care for family
"And I think it was the familiarity of home, really"	Physical proximity with client (Implication: Understanding client personal preferences)

"She wasn't just a therapist"	Latinx therapist viewed as family (Feeling familiar in an unfamiliar place)
"I think in my mom's eyes, she's like a savior"	Latinx therapist respected by family
"I want to be like her"	Latinx therapist demonstration of personal strength as inspirational / Empowering / Lessening stigma
"She's probably gone through some of this stuff"	Discrimination discussed in therapy
"We got to be *chingona*"	Latinx therapist's ability to relate / Not having to explain culture to Latinx therapist
Intersecting Identities (Ex. Trans, POC)	
Therapists & Staff with Intersecting Identities	
"I was definitely validated"	Latinx / transgender therapist / POC staff validating client's concerns
"There's a different level of empathy when you've gone through it yourself"	Therapist understanding experience of being marginalized
Clients with Intersecting Identities	
"People who I could tell had also felt the effects of not fitting in in many treatment situations"	Having marginalized members of therapy groups or treatment setting
Culturally Competent Treatment	
Financial Access to Treatment	
"I actually got my treatment paid for on scholarship"	Treatment center's provision of scholarship and housing / ability to access care
Cultural Awareness of Latinx Culture	
"And I showed that to her and she pointed that out to me. Like, it hadn't even crossed, like, it hadn't even crossed my mind to think about it in terms of race"	Therapist openness to race & ethnicity (Viewing client holistically) / Empowering client to create framework for cultural identity
Awareness of / Reconnecting with Cultural Values	
Religion	
"Doing that was very hopeful"	Religious values incorporated into treatment (Implication: Understanding client personal preference)
Food	
"Food is such an important thing in our culture"	Reconnecting with cultural foods

Family Connectedness	
Family Therapy	
"She learned not to do that"	Awareness, knowledge and skills gained for parent through family therapy / Family support and psychoeducation
Individual Therapy	
"She was like, 'Yeah, I know. This stuff doesn't happen.' Or at least isn't talked about"	Understanding lack of "existence" of AN in Latinx culture & families
"I don't know how to tell my family or explain to people what I'm going through"	Discussions in therapy around explaining ED to family / families' understanding of ED (translating and describing)
Treatment Center Activities	
"Human connection, that connection"	Incorporating Activities / Volunteer work for human connection
Open and Transparent Approach	
"I clicked with her even more because then I feel like I woke up"	Therapist demonstrating affect / Genuine reaction / Mirroring emotional experience / Personal and intentional
"And her family also didn't understand"	Therapist appropriate self-disclosure

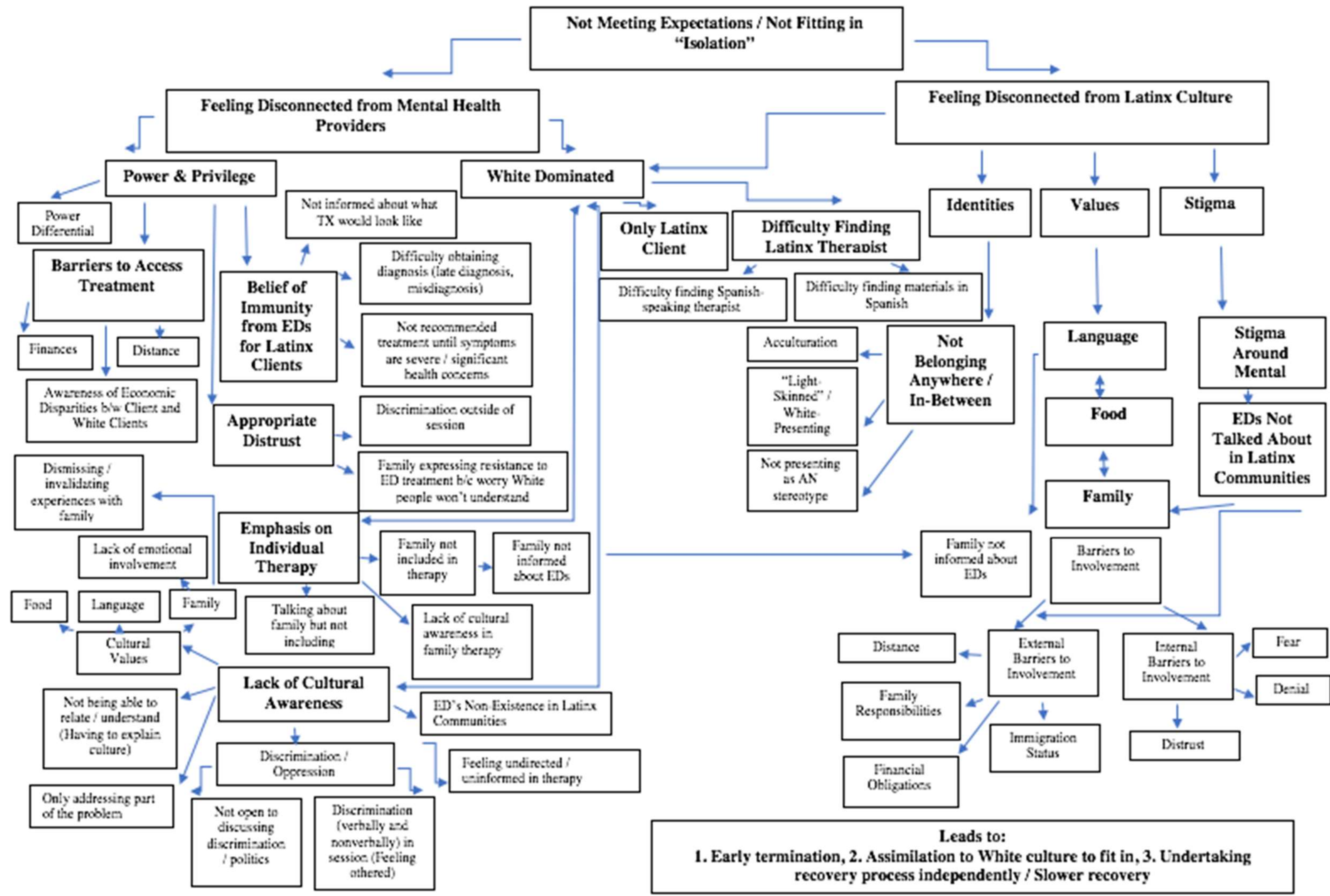
Essence One: Isolation

> *[With] my family and stuff… [I] felt like there was so much explaining that I had to do and such a lack of understanding around the eating disorder and then on the flipside, in the treatment world, there was such a lack of understanding in regards to intersections and people of color and queerness and all of these other things… It's really hard navigating the two and no wonder people of color don't seek treatment. – Ani*

One of the main essences of the phenomenon can be described as "Isolation." This essence involves the client describing experiences of not meeting expectations and not fitting in throughout their time in treatment for Anorexia. The experience of isolation occurs on two levels. On one hand, the client feels disconnected from mental health providers, as a result of power and privilege at work in a White dominated field. On the other hand, clients feel disconnected from their Latinx culture, valuing their own self-care while also valuing family connectedness. As Ani stated in their interview, "There is an immense amount of labor that you have to do when it comes to this kind of back and forth between the treatment facility and your people." The following section will describe the two levels of the essence of "Isolation." See Figure 1 for a visual representation of the first essence of the phenomenon.

Figure 1

Essence One: Isolation



Feeling Disconnected from Mental Health Providers

Power and Privilege in a White Dominated Field

Anorexia Nervosa is often seen to affect only White, cis-gender female, wealthy, adolescent girls. This belief excludes the experiences of individuals with Anorexia who are not White. Since treatment of the disorder has been built on the foundation of this faulty assumption, power and privilege associated with accessing treatment and receiving appropriate care underlie the experience of treatment. The following section will examine power differentials between White clinicians and Latinx clients, as well as significant barriers to treatment, including finances and distance.

Power

Participants described experiencing a power differential in the therapeutic relationship. Believing in their therapist's expertise, participants described feeling confused and questioning their role in the therapeutic alliance. One participant questioned whether they should go to a different therapist but described being unsure of whether this was the appropriate course of action. As Melinda reported:

> I think it was part of… feeling embarrassed. Like, feeling that I was blaming myself for it… I wasn't feeling any better… But I couldn't bring it up. I couldn't bring it up with the counselor. There's something about the position of power here. But even though the counseling relationship was supposed to be a lot more equal, where I was at the time, I didn't see that. So, I was kind of afraid to bring it up, I didn't know how to bring it up that I wasn't feeling any better. And I was definitely even just lying about it. In counseling. Like, saying that I was doing much better, that I wasn't restricting. That I was

> being healthier, right? 'Oh, I'm still eating.' But, I'm staying away from the sweets and the carbs and all that stuff.

Melinda further described the power differential from a cultural perspective, noting that, as a therapist herself, Latinx clients view her as a doctor. She explained:

> And I think that's part of our culture too. I think that we see doctors, lawyers… people in those positions, even if it's counselors. I just realized that lately too, like, as a counselor, my Latino clients see me as a doctor. I've had several clients call me *Doctora*. And I'm, like, 'No, I'm not a doctor.' And yet they still kind of want to hold on to that. So, I think that back then, like, seeing her as one of those people in those positions kind of made it intimidating for me for whatever reason.

Melinda's comments capture a sentiment endorsed by other participants: a feeling that the therapeutic relationship was not experienced as an egalitarian alliance. Additionally, Melinda's experiences emphasize that the power differential present in the room deterred her from openly expressing her concerns regarding disordered eating and led her to deny her symptoms due to a fear of bringing up what was really occurring at the time.

Allie described a similar experience, further stating that her symptoms of Anorexia worsened during her time in Anorexia treatment. She reported:

> I mean, I was with her for about a year, really consistently, every week… for two hours every week, and so, I felt really confused all the time and I was not getting better. I was actually, like, getting physically sicker. Yeah, I felt really isolated.

Allie and Melinda's reflections begin to capture the overall essence of "Isolation." Participants described the unequal power differential in the room as a factor in shutting down genuine expression of their symptomology and concerns. Importantly, these experiences all occurred with

Latinx clients working with White therapists, further heightening the role of power and privilege in the therapy room.

Barriers to Treatment

The next theme of meaning of how power and privilege contribute to the experience of isolation for Latinx clients in Anorexia treatment is "Barriers to Treatment." Significant barriers participants reported included financial access to treatment, as well as proximity and distance to treatment.

Financial Barriers to Treatment

Participants noted the significant financial barriers to receiving treatment, describing not being able to receive treatment due to cost or having limited options in terms of providers. Importantly, Allie pointed out the connection between culture and finances, commenting on the significant financial discrepancies between White and Latinx people. When discussing her perception of treatment facilities before she began treatment, Allie stated:

> And so inaccessible. Seemed very, like, only rich White girls are going to get to do that and I can't do that. Especially because I really didn't have any kind of financial help from my parents and family at that time and I don't know if that's because… I mean, Latinx people just generally make less money than White people… Something that extends beyond just Latinx people but, like, different people of color is that there are very little financial aid opportunities for treatment. Which, I mean, I know now as I look back at stuff but also, it's been my experience that I've just seen, like, there was no way for me to get help if I wasn't super rich. And now I know that there are a few scholarships, but there's not a lot, and they all kind of evaluate how much, like, how sick you are? Which I think is really fucked up. That they really, they try and, like, give it to the people who,

> quote-unquote, like, 'need it most,' but everybody, you know, people who are sick are sick. And I know that's already a thing too within the Anorexia community: we all kind of feel like we have to prove that we're sick enough, I guess.

Allie's powerful words capture the essence of "Isolation," particularly the facet of "Not Meeting Expectations in Treatment." As Allie described, clients feel caught in between two unsurmountable barriers: not being able to afford treatment or having to "prove" that they are "sick enough" to receive a scholarship. Participants described asking for help, only to be told about a specific treatment facility that was inaccessible due to financial barriers; it appeared to participants that these centers only opened their doors to clients in a financial position to seek out treatment and shut out those who were not.

When clients were able to access treatment, several described being aware of the economic disparities between themselves and the White clients in the treatment facility. As Ani stated, "Most of the people that go to that particular facility are very well-off girls… (Laughs). And so, like, my demographic of people may not be frequent flyers over there? We still come around, obviously." Star reinforced Ani's assertions when she stated:

> I have to work. And all of these women in the Center, they were White, they all had money, they had money coming out of their pockets…All the women. They were all White women and they all were paying for their treatment so I, like, now that I'm thinking about it, it did feel weird because I actually got my treatment paid for on scholarship because I couldn't pocket the money.

Star further noted her awareness that her family only had one car, as she pointed out, "Which was weird to people around me, I noticed… because they were, like, all had their own car." Ani

and Star's descriptions both demonstrate their awareness of economic disparities in their respective treatment centers, leading participants to feel "weird" and singled-out.

Distance as a Barrier to Access Treatment

Margarita also commented on distance as a barrier to accessing treatment, noting the lack of available clinicians in her area. While she described engaging in effective outpatient treatment, she noted the significant distance needed to travel in order to access treatment. Margarita noted:

> So, I was seeing a therapist, I was seeing a nutritionist, and I was seeing a pediatrician who specialized in eating disorders… So, it was, like, a two-hour drive from where we were at. I don't know how my mom, I think my mom told me she looked up eating disorder specialists and there was, like, almost nobody (Laughs). And that's why we had to drive so far, we had to drive, like, an hour for my nutritionist, 45 minutes for my therapy and like 2, 2 and a half hours to my doctor. Which was, like, multiple appointments several times a week.

Margarita's description demonstrates the challenge for Margarita's mother in finding eating disorder specialists in her area, as well as the time, transportation, and money needed to engage in a holistic treatment approach.

Belief of Immunity from Eating Disorders for Latinx Clients

The next theme of meaning focuses on a belief of immunity from eating disorders for Latinx clients and a failure to identify Anorexia Nervosa based on White norms. This theme relates to the power and privilege of a White dominated field that dictates what Anorexia should look like and how it is defined.

Not Informed About Treatment

This first theme of meaning includes participant descriptions that they were not informed about what treatment would look like, often leading to a justifiable distrust of treatment. Participants noted being uninformed that they could change therapists and not being informed by providers about what was occurring in treatment. As Star stated, “They were giving me counseling sophomore year and she would weigh me every time I would go in, but I never realized why she was weighing me.”

Participants also described not knowing what to expect from treatment. Melinda stated, “I think just not knowing what counseling looked like because when I lived in Colombia, I never went to therapy.” Allie recounted the stark contrast between her two perceptions of treatment:

> I mean, the way I had always thought of treatment was kind of two ways: Either, like, a state prison kind of where it’s like a cold, dark, scary hospital… And I was so scared, like, I’m going to have to be in a, they’re going to make me eat. I knew from other friends who had been in treatment that they make you eat a lot of food? You don’t have any, like… well, maybe it wasn’t a lot, but in my brain, it was a lot… and that they gave you absolutely no control over what you were eating. Right, which I guess is the point, but it was very frightening for me at the time. And, also the other side of treatment that I knew was that you could go to, like, a resort, go horseback riding in the mountains.

As she discussed her preconceived understandings of treatment, she described her perception of treatment providers as a threat. Allie commented, “Like, if I go to treatment, my whole life is going to be over. They’re going to take away all of the things that make my life easier. It was super scary, I did not want to do it, and I saw them as kind of this unhuman face.”

Participants also described the fear they experienced at the prospect of feeding through nasogastric intubation, also known as an NG tube. Ani stated:

> And honestly my whole, I just said that I had eating issues around eating and I didn't like some foods or whatever, whatever. So, it didn't, it didn't even really click that I actually had an eating disorder until my therapist told me that that's what I had going on. So, I had never really ever, I'd never really been exposed to, you know, anybody with an eating disorder, so, it was really overwhelming. I went in on my first day and a couple girls had feeding foods, you know, NG tubes, and, you know, there was one girl specifically who was, you know, stereotypical emaciated, very emaciated, very extremely underweight and that was obviously very triggering…Like that was very, it ended up being a kind of competitive environment. You know? So, it was, it felt like a lot to jump into and it was, especially felt like a lot to jump into considering this was something that, kind of, had just been introduced to me? Like, you know, I had just kind of found out that this was a problem of mine.

Ani's experience of jumping into treatment sheds light on the experience of isolation from not being informed of what treatment would look like. Ani, who never knew anyone who had an eating disorder, had just been diagnosed, and was thrust into an overwhelming and triggering treatment environment. These experiences illustrate the overwhelming experience of treatment, which appears to be compounded by a belief that Anorexia Nervosa does not exist in Latinx communities.

Urgency of Seeking Treatment

Along with not being informed about what treatment would look like, several participants described not receiving treatment until they were experiencing severe health concerns. As

participants were asked what first led them to seek out treatment, several participants recalled being told by treatment providers that they needed immediate and urgent Anorexia treatment. Messages participants received included, "Give it a week and then you're done," as well as, "You are very sick," and "You're dying." Maria recalled weighing less than 80 pounds when she entered treatment. She stated, "How I'm still alive, like, I don't know. Because I shouldn't have been."

Ani described having to immediately change therapists due to their urgent health concerns. Ani recalled initially working with a therapist for another mental health diagnosis before abruptly beginning Anorexia treatment:

> So, I had a therapist that I'd been seeing for about a year and I really loved her. She was super, super, super helpful and I felt like, yeah, I felt like it was a good fit and my eating disorder at that point had gotten pretty intense and I really rapidly dropped a lot of weight. So, she told me… she wasn't experienced with counseling people with eating disorders and so she basically told me that if I didn't seek treatment for that then she wouldn't continue seeing me.

These accounts from participants demonstrate how far their illnesses had progressed by the time these clients were recommended to access treatment. Indeed, these descriptions raise the question: Why had treatment not been recommended sooner?

Difficulty Obtaining Diagnosis

Several participants described difficulty obtaining an Anorexia Nervosa diagnosis. Specifically, many recounted being misdiagnosed or receiving a late diagnosis. Five of the seven participants noted that they did not receive diagnoses until many years after their symptoms of Anorexia Nervosa began. Star noted commencing restriction in middle school and having the

illness continue to progress, but not receiving an Anorexia Nervosa diagnosis until college. Angela remembered having an eating disorder "for a very long time," recalling that her symptoms started at age 12 or 13 and she was diagnosed in college. Ani stated that they began struggling with an eating disorder when they were 10 but were not diagnosed until they were 20.

When interviewing Melinda, the primary researcher asked her if anything led her to recognize that she had disordered eating. Melinda stated that she saw dieting as "normal.'" Currently, at age 26, Melinda noted not realizing that she had an eating disorder or practiced disordered eating until three or four years prior. Melinda described her experience of disordered eating and dieting as a norm in her household and beyond, leading her to view restriction as normal and acceptable.

Allie's experiences demonstrated a perception of providers regarding Latinx clients' immunity to Anorexia as a significant barrier in receiving an Anorexia diagnosis. While Allie noted having issues with eating since she was very young, she recalled her symptoms becoming more severe at age 15. As she discussed her experiences receiving a diagnosis and treatment, Allie stated:

> A lot of moments that also made me feel invalidated or isolated or maybe that I didn't even have an eating disorder was, I said that I'd been having it for… I knew that I had been experiencing disordered eating my whole life and had really fully swung into an eating disorder when I was 15 but I would talk to doctors about it? Or my dad would tell doctors, 'She doesn't eat enough,' or, like, 'She's not… you know… she's too skinny,' or whatever and the doctors would really brush it off completely. And just tell me, like, 'Oh no, she's just…' A lot of times, especially when I was dealing with this in high school, a lot of people would actually tell me that I had, they were like, 'Oh, no, she's a curvy girl.

> She's going to be fine.' Like, 'She…' They would say things a lot about, like, especially when the doctors were also other Latinx people, I would hear a lot of times jokes about, like, a meal that my grandparents should make me or that like, 'Don't worry,' they wished they were as skinny as me… So, it was, like, 'Oh, these are doctors. They're supposed to help me.' And I would tell them what was going on and then they, I think, often just kind of thought it was like a joke or it wasn't a real thing. So, I actually had a really hard time obtaining any kind of diagnosis.

She further noted:

> There were a couple of times too in the intake process where, because I had never before obtained a diagnosis, in the intake process it was really difficult for me to get, like, meetings with people because they weren't sure that I had one? And that was really bizarre for me… Because I was telling them my behaviors and… that was one of the moments that I feel like there was definitely some institutionalized racism in those settings. Where they were like, 'You can't. You're immune. People of color don't get eating disorders.'

Allie's reported experiences of providers not believing that her symptoms were a "real thing" demonstrates her providers' beliefs that Latinx clients are immune to eating disorders. This dangerous assumption resulted in Allie being invalidated by providers and not receiving an Anorexia diagnosis, leading to progression of the illness and even more severe health concerns. This theme of meaning will be further explored when discussing "Not Presenting as the Anorexia Nervosa Stereotype."

Comorbidities with Anorexia

The last theme of meaning pertaining to the belief of immunity against eating disorders for Latinx clients involves comorbidities of additional mental health concerns alongside symptoms of Anorexia. Participants noted additional diagnoses, such as body dysmorphia, PTSD, depression and anxiety. Several participants noted the connection of other mental health concerns with their symptoms of Anorexia. For instance, Angela stated:

> I was co-diagnosed with Anxiety? And, so, a lot of times… like, when growing up and especially through high school and stuff, my disordered eating habits, like, I would come from, like, 'Oh, I'm so anxious that I just can't eat.' Like, 'Oh, I'm so nervous,' 'I'm so busy.' 'I'm just going to, like, go without it." Like that and I think that was part of my disordered eating experience.

Moreover, Margarita recalled, "I struggled with depression. Like, I think the eating disorder was just, like, when the depression got so bad that it, like, this other disorder came up because the depression was untreated." With treatment specialists providing late diagnoses or misdiagnoses for Anorexia based on a perception of immunity for Latinx clients, additional mental health concerns, and their connection to disordered eating, were overlooked as well.

Appropriate Distrust

The next theme of meaning, "Appropriate Distrust," focuses on two components that impact feelings of distrust towards White therapists: family not approving of attending therapy and discrimination outside session that resulted in distrust of a White therapist. These two areas contribute to the experience of feeling disconnected from eating disorder treatment providers.

Family not Approving of Attending Therapy

Participants described experiences in which their families expressed disapproval of attending therapy or resistance to Anorexia treatment because of a worry White people would not understand. As Star stated:

> And they're all just like, 'Eat! It'll fix everything! Just eat!' And they were actually trying to get me out of treatment, my family. 'We don't want you going there anymore.' Because the people were White too.

Angela echoed this experience, as she said:

> My parents didn't really approve of therapy and they didn't really understand the meaning or the necessity behind it? And so, anytime I tried to bring up, like, 'I need to go to this person,' and 'I need to go get help,' there would be pushback. Yeah. They would just be, like, 'Oh, go to church.' 'Pray about it.' 'Why don't you just talk to us about it?' They didn't really understand that I needed professional guidance on this and more than just talking to my parents?

Four of the participants recalled receiving pushback from parents or family members regarding the prospect of seeking Anorexia treatment. Participants described the worry and confusion that they believed their parents were experiencing when they did not understand what was happening for their child. Indeed, Allie noted that her family refused the possibility of treatment. Margarita recalled a friend's mom and her siblings expressing their concerns to her mother about her health. When asked how her mother responded to these encouragements, Margarita stated, "I remember my mom getting really upset. Like, 'Why do you talk to the therapist and not to me?' Like, 'What can't you tell me?'" Margarita's family's reluctance depicts a common response across participants: a belief that problems should be discussed within the family, a preference for

religious guidance over therapy, as well as a lack of understanding regarding Anorexia Nervosa and its treatment.

Discrimination Outside Session Impacting Distrust of White Therapist

The second component of "Appropriate Distrust" involves a distrust of White therapists by participants due to experiences of discrimination outside of session. Melinda recalled:

> I think by that point, I hadn't had really good experiences… with White people in general. Or just Americans. Not White people, I think it was just Americans in general. I hadn't had really good experiences in the U.S. When I was with my guidance counselor or with the financial aid lady at the first college I applied, the community college I went to… so, I think some of that was kind of bleeding into that. Of, like, here's this other American lady that I'm going to be talking to. Like, 'What's going to happen?' I think it's almost, like, this expectation of what it was going to look like and then for me to have that first session and… to not feel, like, that connection? I think that kind of definitely added to that wall.

Melinda stated that this contributed to her not wanting to bring up experiences of discrimination with her White therapist. She noted, "I never thought once about bringing that up with the other counselor." Moreover, she noted experiencing anxiety that a White therapist would not be able to understand her. "I remember being, feeling so anxious that, like, I remember reading her name and I was just, like, 'She sounds so American,'" Melinda recounted. "And so, I think building up some of that anxiety really. Like, 'Oh, this person…' Like, all of this insecurity about my English started coming up."

Allie described a similar distrust of treatment providers, based on experiences of discrimination at her university. She stated:

> And the schools were really, really, the school was very unsupportive. So, I think even looking at other treatment options, you go there, you're going to be doing yoga and swimming or whatever. It seemed very akin to exactly how [University] was and how much I think White people had contributed to me feeling really bad about myself all the time.

After encountering resistance from her family for attending treatment, Star recalled questioning going to treatment based on her worries that White people would not understand where she was coming from. She recalled asking herself:

> How are these White people going to help? They don't know what I'm going through. They don't know that my mom's ex is in the detention center. How are they going to grasp it?

Star's reflections, and others, exemplify an appropriate distrust for White treatment providers and a worry that White therapists would not understand their experiences, based on experiences of discrimination and oppression perpetrated by White people. Clients carried these experiences into therapy as an adaptive response to coping with potentially oppressive forces in the therapy room.

Only Latinx Client

The next theme of meaning pertains to the experience of being the only Latinx member of a group or treatment setting. Indeed, all of the participants who attended inpatient treatment and did not work with a Latinx therapist commented on being the only Latinx client in their respective centers. Participants described experiences of being exotified in treatment, experiencing isolation, and encountering group resistance to discussing experiences of oppression that do not impact White people. Many of the participants described a lack of cultural

awareness in group therapy and often connected this to lack of representation of people of color, particularly those who identify as Latinx, in Anorexia treatment settings.

Angela described her experience of not feeling that the White members of the group understood her cultural experiences as she stated:

> Although it was nice to have a group of women who I felt like had shared experiences with disordered eating, one thing I was the only Latina in that group? And so… whenever I would bring up something about culture or background or whatever, there wasn't, I guess, a mutual understanding of that? And, so, that's something where, like, if there was a support group for Latina women who are going through this… I feel that would have been even more impactful or more powerful. You know, just to, like, have not only those shared experiences but also coming from a similar background of people who understand, like, understand what you're going through with a certain family thing or whatever it might be.

Several of the participants described homogenous treatment settings where they rarely, or never, encountered other clients of color. Ani described feeling "on display" and exotified by other White clients. They noted:

> Having my family come in for, like, visits and stuff on weekends, some of the other patients and my individual therapist saw, you know, my dad and my sister and my mom and saw that… (Laughs) I have, I come from brown people? (Laughs) And, so, then, you know, because on the floor, pretty much all of the other patients were White girls and pretty, pretty well-off White girls at that. And so, to them, I became ultra-Mexican… And so, I got asked by my peers, I got asked a lot of questions, like, what that was like and stuff.

Ani experienced being viewed as “ultra-Mexican,” and feeling as though they were singled out because of their background. They noted receiving a lot of questions about their intersecting identities, of identifying as queer and mixed-race, stating that White clients would ask them, “What’s that like?” They stated, “I felt like I was kind of seen as the one answer to all of their questions about people of color.” By being exotified by the White clients in their setting, Ani felt targeted as the spokesperson for all people of color, further compounding their experience of isolation.

When asked if cultural backgrounds and intersecting identities were discussed in group therapy, Ani acknowledged that these topics were never brought up. “The demographics of patients didn’t really change,” they noted. Maria had a similar response when asked if cultural identities were brought into treatment. She recalled, “There just wasn’t an opportunity for it… there wasn’t a lot of diversity in our group.”

Maria noted being one of the older women in the group and described the rest of the group as White. “All White,” she said. “Definitely all White.” When asked what that experience was like for her, Maria said:

> I felt like the not cool girl. There were definitely, like, the mean girls. I would have to say. And two in particular that stood out to me that greatly disliked me and made it known to me that they disliked me. This is so dumb of me looking back in hindsight, but I totally felt like, ‘I’m so not cool. I’m just here to go through the motions. Whatever. Don’t care.’

Maria’s experiences of being in a “sea of White” in her treatment setting negatively impacted the way in which she viewed herself and impacted her role with the other clients in the treatment center. She noted, “I’m pretty sure I was the only Hispanic during the time that I was there.”

However, these dynamics appear to have been completely overlooked or ignored by treatment providers.

Allie described her reactions in group therapy to brutal police shootings of Black men being ignored by White group members:

> The Center itself is still pretty homogenous and there are plenty of times in group therapy room that I felt very angry because there have been… there are days that I'll go in that something is happening, something awful in the world for people of color… And I'll come in and nobody seems affected by it or like during our check-ins, we'll go around and a lot of the, a lot of the White people will just, like, mention their week as normal? And I used to kind of, like, fall into that or force myself to fit that same mold, where I just, like, 'Oh, I guess we're not talking about it here.' Until, but there was a point, right when Philando Castile got shot where I was like, I, I went to therapy that morning and I was a complete wreck…And I was, like, 'I cannot, I'm at the point where my eating disorder behaviors are, like, coming back pretty full on because I cannot handle the fact that this is the world that we are in.' And… the room was, like, completely silent. People got really uncomfortable, they would turn their eyes down or not look at me or, like, shift in their seats. There were a couple of girls who actually got up and left… And it was super uncomfortable because there were lots of people in the room who didn't understand what was, they couldn't understand where I was coming from or, like, why I would feel that way… We were supposed to be allowed to talk about that. We were supposed to be allowed to talk about whatever was impacting our life on that day and there were people in the group who would talk about how different political events that were affecting women were affecting their eating disorders.

Allie recognized that the murder of Black men in U.S. society was impacting her eating disorder. However, she described not being understood and being disrespected for her deeply personal response to racist actions against people of color. She recounted feeling as though it was acceptable for politics, oppression, and discrimination to be discussed in the group if they impacted White persons. She said, "But it stops for them at a certain point. Where it was, like, I could talk about, I could talk about abortion rights for one second and be completely validated and then in the next second I'm talking about Philando Castile and they would freak out." These experiences shed light on the layers of isolation that occur as the only Latinx member of a treatment group or center: feeling lost in a "sea of White," not feeling that there was understanding of cultural experiences, being exotified and singled-out based on intersecting identities and being silenced from speaking about Black men being killed in our communities.

Difficulty Finding Latinx Therapist

Five of the seven participants explicitly noted difficulty finding a Latinx therapist who specialized in eating disorders, specifically Anorexia Nervosa. Five participants had never worked with a therapist of color for Anorexia treatment and had all worked with White cis-gender female therapists. As Allie stated, "I've never seen, in my life, I've never seen a therapist of color."

Melinda's story captures the push and pull between finding a Latinx therapist and finding an eating disorder specialist. In her work with a Latinx clinician, Melinda recalled not feeling that her clinician was equipped to work with eating disorders, as evidenced by encouragement of eating disorder behaviors. However, when Melinda began to work with a clinician who specialized in eating disorders, she recalled feeling that the eating disorder work was not

effective, because her culture was not incorporated into treatment, noting the inextricable link between her eating disorder symptoms and her intersecting identities. She stated:

> It was almost as if I have to settle between… I can either go with someone who understands my culture and understands my language, or I can go with someone who knows more about this other stuff that I wanted to work on, but they didn't understand why I was so sad that I wasn't living with my mom anymore… It was, like, I had to settle. I… I don't think that should have been the case.

Melinda's account epitomizes the experience of several participants of not being about to find a clinician who fit both their treatment needs and their cultural needs.

Difficulty Finding Spanish-Speaking Therapist & Materials in Spanish

Melinda also described the challenge of finding a Spanish speaking therapist in general, let alone a Spanish speaking therapist who specialized in eating disorders. She further explained that finding a Spanish speaking therapist was important to her, as she had just arrived in the United States and did not feel confident about her English skills. As she recalled that time, Melinda described not being able to find any eating disorder specialists who spoke Spanish.

Additionally, Allie recounted requesting materials in Spanish to send to her grandparents during intake. "My grandparents were causing a lot of pain for me at home," she said. "Saying, like, 'that this couldn't be happening, that this wasn't real,' that I just needed to eat, or come back home and have my grandma teach me how to cook or whatever." When Allie asked the treatment center if they could provide materials to send to her grandparents, they said that they "didn't have any." "They were just, like, 'We don't… we can't… we don't have that. We've never had to deal with that.'" This unwillingness to provide materials that would have ultimately assisted Allie in her treatment and progress led her to question the center she was in. She recalled

asking herself, “Well, why am I here now? What am I doing here?” Not only do these moments provide vivid examples of a lack of resources contributing to disconnection from mental health professionals, but these experiences also exemplify a White dominated profession driving a wedge between clients and their cultural backgrounds.

Negative Comparison of White Therapist to Latinx Therapist

Star was one of two participants who worked with a Latinx therapist specifically for Anorexia treatment. However, when she could no longer continue seeing this therapist, due to the therapist completing internship training, Star had to search for someone new.

> So, I had to see someone else after that? I saw one woman, and she was a White woman… And I didn’t like her. I just couldn’t… I just couldn’t. I was with her for like one day and then never came back. I was like, ‘I’m never going to find this again!’ And I haven’t gone to therapy in a long time, but I just feel like after my therapist, I don’t know.

She described, understandably, comparing the White clinician to her previous therapist, who identified as Latinx. She noted, “Nobody is going to compare. Like, why even try.”

As described above, Melinda first worked with a Latinx therapist but, when she realized she needed more focused disordered eating specialization, she began working with a White therapist. She commented, “I think I was comparing her to that first counselor. I think I was comparing her to my people and my culture and how we talk about things.” These two instances capture the negative comparisons of White therapists to participants’ previous Latinx therapists. When exploring another theme of this essence, “Lack of Emotional Involvement and Connection with White Therapist,” additional information will be provided on these treatment experiences with White clinicians.

Lack of or Incompetent Family Therapy

Three themes will be explored when discussing lack of or incompetent family therapy: the family not being included in treatment, culturally incompetent family therapy, and clients and families feeling blamed for not meeting expectations in treatment.

Family Not Included in Treatment

Three participants acknowledged not being offered family therapy by their treatment providers. "We didn't even do a family therapy session while I was in [treatment]" Maria noted. Margarita's account echoed this fact:

> We never had family therapy or anything like that. Never had my siblings or my dad come in… I didn't really have any feelings about it. I think now, as a social worker, I'm like, 'Oh, why didn't they do that?' (Laughs). Like now that I'm working with families, I'm like, 'It kind of makes more sense to do that.' But no, I was feeling pretty isolated from my whole family. During that time. So, I don't know if that would have effected anything. I remember my mom getting really upset, like, 'Why do you talk to the therapist and not to me?' Like, 'Why can't you tell me?'

Allie noticed a discrepancy between her White friends being offered family therapy, while this was not presented as a possibility by her therapist. She stated:

> I was never offered that… and even at times when I would tell my therapist, 'My family is in town. My dad is here visiting from [my hometown] this weekend,' nobody ever offered for them to come or said that I could bring them. I remember, actually, [my therapist] told me that if I wanted to add someone it was, like, an extra charge or something to bring a parent in. Which just made it feel like it wasn't, like, didn't care about it…

As seen in these instances, these participants all questioned why the possibility of including family in therapy was excluded from their treatment. By not including family, participants noted their beliefs that their therapists did not care or that their therapists did not find it important to include their families in treatment.

Lack of Cultural Considerations and Discrimination in Family Therapy

Maria and Ani both described experiences of culturally incompetent family therapy. Maria stated:

> When my parents were incorporated into therapy, that, like, exploded… in my face… I had been prepared, like, my individual therapist was, like, 'Alright, we're going to have, like, a family session. We're calling your parents.' And she had, like, prepared me for the conversation and helped me, like, map out what I wanted to say? And we got nowhere into it because all my parents could hear was, 'It's your fault.' Even though I didn't say the words to them, like, 'it's your fault,' I think them just hearing, or listening to me say that part of this was as a result of, like, stresses caused by the family, all they could hear on their end was, 'Oh, so it's our fault. Okay, so it's our fault.' So, that completely shut down the conversation. Like, done. Done. It was like that. Because again they were still stuck in that mentality of, like, this is, this is not a mental illness.

She added:

> I had that one conversation with my parents and my therapist and, like, forget it. That was, just, shit hit the fan because it was, like, all of a sudden, all their fault. So, we ended up in, like, a shouting match with me ending up in tears. And just hanging up.

As she described her therapist's role in this encounter, Maria recalled that her therapist was "nice" but not "culturally trained… to deal with a Hispanic family." Maria wondered if her

therapist had ever worked with Latinx families before. While Maria gently protected her therapist as she described this disastrous encounter, describing her therapist's cultural incompetence as "no fault of her own," Maria brought up an important prerequisite to this conversation: she stated that her parents did not understand Anorexia as a mental illness. By bringing up this "taboo" topic without the foundation of understanding for her parents, Maria described her parents shutting down and assuming that Maria's symptoms were their fault.

Ani also described a culturally incompetent family session in which blatant discrimination by the therapist led their father to shut down in conversation:

> And you know, the other thing is, obviously I mentioned this before but, like, having the disconnect and a lack of understanding with, like, my family's values and that maybe just because, maybe just because there is specifically a language disconnect. Like, my dad speaks English, but he has a very, very, very thick accent. And my parents did come in to a session one time and so… you know. Watching, watching that interaction was a little bit frustrating because there's a constant assumption that he doesn't understand things? Because he has an accent? That was definitely something I picked up on in this facility and I understand that that probably wasn't my therapist's intention but, you know, my mom who is White and my dad who is Mexican, very dark skin with a thick accent, I watched her speak to them differently. In the same room. So, that was definitely something and that was, they only came into a session once but that was, that was a frustrating thing to watch. And that was not particularly helpful considering the setting I was in and how emotionally charged it was already? …You know, and when that happened, my dad shuts down. So then, of course, it's harder for him to be receptive to whatever we were trying to talk about.

Ani recounted the frustration and exhaustion they experienced in witnessing their therapist discriminate against their father based on his skin color and accent:

> It's scary having your parents come in, it's hard to have this scary conversation, everything's feeling pretty emotionally charged… And then it feels like, you know, all of the stress and this and that, like, for only to have him shut down and get frustrated and not be receptive or retain whatever was said. It felt like all for nothing. You know? And it was something that 100% could have been avoided.

These disheartening examples by Maria and Ani vividly depict culturally incompetent family therapy and a lack of understanding around client cultural backgrounds causing conversation with families to shut down, negatively impacting both clients and their families.

White Therapist Blaming Client / Family for Not Meeting Expectations in Treatment

Allie described her therapist viewing it as her fault that she was not able to ask for help, financially and emotionally, from her parents. "They said I wasn't advocating for myself or I wasn't being able to talk to my family," she recalled:

> I would tell them what was happening for me and I would ask them for help and they would tell me, 'Well, you have to go to this treatment facility' or 'You have to get treatment at this outpatient facility' or whatever and I was not able to pay for that at the time? And I remember specifically I couldn't think about how I would talk to my dad about that and about what I would need because he was really the only one that I could talk to about needing help for that. Because my mom didn't really think it was a problem. So, I would talk to my dad about it and I couldn't even think about how I would get him to understand.

Margarita also described feeling shamed and blamed by her therapist. She stated:

> I just remember being really uncomfortable and she was just saying, 'Don't you see how you're making your parents suffer? Don't you see how you're making your family suffer? Like, how could you do this to your family?' Like, 'You're causing people harm.'

Additionally, Star and Angela both described experiences in therapy where their families were blamed or not understood for not meeting expectations in treatment, specifically not attending family sessions. Star, for example, discussed trying to explain her mother's undocumented immigration status to her White therapist. "So, I tried explaining that to her and she just didn't understand a lot of things that were going on… she just couldn't comprehend how my mom wasn't there, why she wasn't there." Lack of awareness of cultural and political factors led to Angela's therapist not understanding why her mother did not attend sessions. She recalled, "I think once or twice she brought up the idea, like, 'Oh, why don't we have your mom in here, try to have a session together,' and stuff like that but my mom is a very religious person and she's just like very Catholic which is like the common faith for a lot of Latino moms." Angela's mother's apprehension about therapy came from a preference for religious guidance and prayer over talking to a mental health provider. In both of these examples, participants described feeling as though cultural factors, specifically undocumented status and religious preferences, were not considered or understood by White therapists when discussing including family in treatment.

Lack of Cultural Awareness from White Therapists

The next section concerns the lack of cultural awareness that these participants described White therapists exhibiting. Four main areas will be addressed: a lack of responsiveness to cultural factors, feeling disconnected from cultural values in therapy, experiences of

discrimination and oppression being dismissed in therapy, and therapists not understanding the lack of "existence" of Anorexia Nervosa in Latinx communities.

Lack of Responsiveness to Cultural Factors

Participants noted feeling that cultural considerations were not adequately included into treatment. Firstly, participants described feeling that their therapists only addressed part of the underlying problem. Secondly, they noted feeling that they had to explain their culture and that their therapists could not relate nor understand. Lastly, participants recalled feeling as though their experiences were stereotyped based on their cultural background.

Feeling that Therapist Only Addressed Part of the Problem

Star and Angela both described not feeling as though underlying issues that contributed to disordered eating were addressed. As Star noted, "She… would just try to get to the eating part… 'So, this is what you have to do so that you can eat again. Here's your plan.'" Star described her confusion and dismay that food was the only thing discussed in her treatment, leading her to question if she should see someone else.

Angela described a similar experience in a university counseling center, which offered a limited number of sessions. She stated:

> Obviously, like, when people have serious mental health issues, you're not going to have that solved in, like, 5 sessions. So, that's something where I went through the school and they were okay, but it was very… like, not exactly tackling the underlying issues or motivations behind it. It was really just, like, this is how you can be mindful. This is how you can, you know… I don't know. It was like their sessions were focused on having more, I guess like, coping tools? Rather than actually going into the issue.

By not delving into what was actually going on for Star and Angela, both participants felt dismissed and as if their therapist only focused on part of a larger concern.

Therapist Not Understanding or Relating

Participants also felt that they were put into the uncomfortable position of having to explain their culture to White eating disorder specialists. Melinda recounted bringing up experiences with family and finding it disappointing that her therapist did not understand what it meant to be in a collectivist culture. She further stated:

> I think I was going through a lot of culture, like, acculturation kind of stuff at the moment… Where I was trying to figure out who I was? Like, here I am away from my family and I think a part of me was looking for someone like that in the counselor too? Like, to feel less isolated? And whenever I would go in, it was, like, she would reflect stuff back to me and it was never quite it.

While Melinda was hoping this therapy experience would provide her a moment of connection during an isolating time, she, instead, felt that her White therapist could not accurately understand and reflect back what she meant. Allie also stated that her therapist could not understand what she needed her to understand:

> I would tell her about things… how I felt a lot of trauma associated with White people. Especially as it came to my eating disorder and my eating disorder recovery. Or, and then also feeling, I would often talk to her about how I felt I wasn't Mexican enough? To be validated by that community either? And so, I really felt caught in this place that I just didn't belong anywhere. And I would try to talk to her about it and she would get so uncomfortable.

Angela also stated that her therapist could not relate or empathize to her background, which left important stories, context, and background out of therapy.

Stereotyping and Generalizing

Margarita brought up experiencing microaggressions based on broad generalizations about her culture made by her therapist:

> I feel like other therapists have made it, other White therapists have made it, like, they kind of overstate my race? I don't know if it's that they're trying to be culturally competent but also kind of, like, stereotyping in a way. Of, like, 'Oh, like, that's very common in Latino people.'

By overstating her race, Margarita's therapist made inaccurate assumptions which failed to view Margarita as a holistic person with her own identities. She recalled this being particularly true in terms of family values. She said, "I think people have mentioned the whole family aspect a lot. Like, because I'm Latina, I value family over everything else. And that's not really true. (Laughs)."

Margarita also recalled a therapist committing microaggressions in session, generalizing based on her conceptions of beauty. Margarita stated:

> I remember one therapist telling me that, like, I think I brought up looking ethnically ambiguous to her and how it had been kind of, like, an ongoing issue and she just kind of, like, brushed it off and said that it was, like, 'Being ethnically ambiguous is, like, really big in Hollywood right now. It's, like, really beautiful.' And I think she thought she was giving me a compliment. Which she sort of was but it wasn't really validating what I was saying. Like, I needed her to tell me I'm beautiful, don't worry about it (spoken sarcastically).

These three examples from Margarita illustrate the dangers of making blanket assumptions and generalizations about clients based on their demographics.

Cultural Values

The next section will explore the experiences of participants being disconnected from their cultural values in therapy. These values include family and connectedness, food, and language. Margarita's comments above are important to consider throughout this section of analysis. While some participants hailed the importance of these cultural values in their recovery, others did not view them as central to their recovery and healing. Margarita's words provide a needed reminder that the client is the expert of their own experience and generalizations and assumptions based on demographic variables can cause harm and thwart progress for clients.

Family and Connectedness

Participants described several areas in which they experienced a disconnection from their value of family and connectedness in treatment including: lack of understanding regarding family roles, lack of understanding of respect and expectations around food in the family, feeling as though White therapists dismissed or invalidated experiences with family, discussions in individual therapy with White therapists about relationships with family members, and lack of emotional involvement and connection with White therapists.

Lack of Understanding Regarding Family Roles

Melinda and Maria talked about not feeling as though Latinx family roles were understood by their White therapists. Being the oldest in their families, both Melinda and Maria felt that it was their responsibility to care for their parents in times of need. Maria described engaging in treatment at a "tumultuous time," as her mother began treatment for opioid abuse. She recalled:

> I mean, it really got so bad at my parents' home that my stepdad and my uncle were talking about sending my sister to me in [my city]. Now, explain to me how a 22-year-old is supposed to take this? Living in [my city], being, like, 'Oh, I might end up having to adopt my 16-year-old sister and bring her up here with me. Awesome.' And trying to do my own healing. And trying to figure it out. And I had people telling me, 'Well, you're going to have to come down and, like, take care of things at home because you need to take care of your mom.' And I'm like, 'But I just worked so hard to get here! You can't take that away from me!'

While Maria described her frustration towards the responsibility placed on her by her family, her urge to nurture stayed with her into the treatment facility as she cared for other clients. "That's what I was there for," she said. "Since I couldn't be there for my sister, I was, like, 'Well, now I have, like, seven little sisters here. They're all, like, my little ducklings.'"

Melinda also discussed the responsibility she held for caring for her parents, as the oldest child. When Melinda described the care she provided for her mother when she experienced depression, her therapist called the experience "neglect":

> They were… kind of blaming my mom and calling it 'neglect.' And I'm like, 'You don't understand. It wasn't neglect. That's not… in Latino culture there's a responsibility of taking care of your elderly.'

Melinda recalled not liking that she had to explain family roles and expectations to her therapist and recalled feeling offended that her therapist did not understand.

Lack of Understanding of Respect and Expectations around Food in the Family

Ani and Margarita both discussed not wanting to disrespect their families by communicating boundaries around food. However, both participants felt that this consideration was overlooked by White eating disorder specialists. As Ani stated:

> Trying to find a balance between, you know, opening a line of communication with my family which is something my therapist wanted me to do. Which, obviously, I was on board with, I thought that would be helpful. But trying to find a way to make my therapist understand, like, you know, it's, there's this other layer of not wanting to disrespect my parents and disrespect the elders in my family by stepping out of the room during a meal or, you know, only finishing, or only having a few bites or whatever. Like, if I, I feel like if I were in a family with a different cultural background or something, like, I felt like it would maybe be easier to communicate my boundaries with food and explain that maybe, you know, I'm not trying to be a jerk by not finishing my plate or by saying I'm not hungry and, or trying to explain what safe foods were or… you know. There were just a lot of solutions that my therapists that my therapist offered that I didn't feel like were a good fit considering my family's background. I felt like if I tried to do some of the things that my therapist offered in terms of explaining this to my family that there would be maybe a lack of understanding on my family's side of things. And so, it was kind of hard to balance the two sides.

Ani further described food being an important aspect of Latino culture, commenting that food is offered as a sign of care by elders in the family, and there is an expectation that you eat it. "You gotta eat it," they explained. "It's super rude if you don't eat it and it's super wasteful if you only eat a little bit." Margarita described similar expectations in her family:

> I remember bringing up, like, not really liking the food that my mom made because I felt like it was really unhealthy and that was really hard for my mom. Like, in Mexican culture, you don't turn down food. Like, it's really rude to turn down food. It doesn't matter if you just ate. Like, if somebody made you food, you've got to try it. Like, if there's a potluck and there's 50 different things, you should try, like, at least a little bit of everything… It's, it's very disrespectful. And so that was a point of contention between me and my mom and I think I remember bringing that up, like, I didn't want to eat her food and I just thought it was unhealthy.

As an integral part of Ani and Margarita's Latinx cultural experience, food and expectations around food presented a challenging dynamic. On one hand, participants were experiencing a disorder which impacted their relationships with food. On the other hand, participants expressed concern about offending or disrespecting family members by refusing food or setting specific boundaries around their preferences.

Experiences with Family Dismissed and Invalidated by Therapist

Participants used the word "dismissed" and "invalidated" to describe how White therapists responded when they discussed their families in session. Star stated, "She wouldn't understand a lot of where I was coming from. She would be like, 'Oh, your mom is never there,' But she wouldn't understand… She just would dismiss a lot of my experiences."

Melinda and Ani both noted feeling like they were not being heard in therapy. When Maria's treatment provider used the word "neglect" regarding her mom's mental health concerns, Melinda recalled thinking, "Oh, this person really doesn't get it." She further described feeling angry:

> Like, sharing about my family, about my mom and just not feeling validated at all. And I think it was especially because of how important my family is to me. And I think that's a big deal in the whole Latino culture really. And for her to tell me that my family had intentionally or in some way harmed me on purpose, that made me very angry. I got very defensive.

Ani recounted their therapist saying, "Well, you know, it's your family's responsibility to hear you out and try to help you get better." However, Ani felt that their therapist was dismissing other important cultural factors and not taking a holistic approach to understand where their family were coming from.

Discussions in Individual Therapy about Relationships with Family Members

Four participants brought up conversations that they had in individual therapy with White therapists about their relationships with their family. As seen above, Ani described having individual conversations with their therapist regarding setting boundaries with their family around food without their therapist recognizing how difficult it would be for Ani to explain these concerns to their family and without considering that there could be a lack of understanding from their family. Ani was encouraged to verbalize their needs by their therapist, without the therapist considering the ways this could be interpreted by their family. They recalled:

> That was one thing that my therapist kind of wanted me to focus on and she wanted me to practice being really firm and being really direct… And there's value to that for sure but I just feel like the ways that she wanted me to communicate, while the intention is not to be disrespectful to my parents, it could, I could, like, 100% feel that it would offend my parents if I tried to talk to them that way. And so, it kind of felt like I was spinning my

> wheels because I tried to explain that and there was just kind of a lack of understanding there.

Maria also recalled often talking in individual therapy about the tension she was experiencing with her mom:

> I had a lot of, like, pent up, I guess, anger on top at that point, so the conversation that I was having in individual therapy were a lot linked to that struggle with the parents and the family unit. So, that was, that piece of the puzzle, like, trying to figure out in individual therapy, like, having conversations, just airing that out a little bit. Did it ever help or anything? Not really, because I never ended up having conversations with my mom and dad about it anyway.

While Maria used the space in therapy to discuss difficult relationship dynamics at the time she was in treatment, she also acknowledged the lack of helpfulness, since these concerns were never discussed with her family members.

Angela, similarly, described having conversations with her therapist around tension in her relationship with her mother, but without tying in the impact of culture or background on the relationship. She recalled being asked questions such as, “What is your relationship with your parents?” “What is your relationship with your siblings?” However, she described feeling as though the focus was only on the relationship. “And not really in the context of, like, part of this relationship is because she’s, like, a Latino mom,” Angela explained.

This experience of discussing family in individual therapy, and a lack of focus on systems, brings up several important points regarding the themes of disconnection from Latinx culture and disconnection from mental health providers. Firstly, these examples represent an emphasis on individual therapy, promoted by a White dominated field that values individualistic

culture. This is reminiscent of an earlier theme participants described of not being offered family therapy or experiencing culturally incompetent family therapy. Secondly, these experiences emphasize participants being encouraged to have conversations and make decisions about their family, without recognizing the value of family connectedness. Recall the example Ani described: feeling as though they would offend their parents if they followed their therapist's direction, but also wanting to do their best in treatment. Ani's example encapsulates this essence of the phenomenon: the isolation of being pulled in two different direction by their mental health needs and Latinx values and the exhaustion of having to navigate these two sides while fighting for their own healing.

Lack of Emotional Involvement and Connection with White Therapist

The last component of family connectedness pertains to the expectation from participants that their therapists should be emotionally involved as a component of treatment. Melinda recalled her first interaction with her White therapist:

> No handshaking at all. Just, 'Hey, how are you? Come on back.' And she sat behind a desk and I sat on this couch that wasn't even, like, across from the desk. It was, like, diagonal from the desk and on the other side of the room. It was just a lot colder. And even, I remember our first conversation was about how many sessions Medicaid covered, which was very disappointing to me. Like, not even, like, 'Oh, how long have you been here in the U.S.,' or 'What are you majoring in?' It was… that was the first conversation that we had.

When asked what the most discouraging thing about this experience was, Melinda stated:

> It was discouraging that it wasn't personal… I feel like in my culture, we can get personal very quickly. And I didn't feel that from her. There wasn't any rapport building.

> That's the thing. There was no small talk. It was, like, straight to business. And a part of me, that just made me think like, 'This is the doctor's office again.'

She noted feeling no connection with her therapist and feeling like she was at the doctor's office, listing out her symptoms. The coldness, her lack of ability to relate, and the lack of connection caused Melinda to feel discouraged and disappointed with her very first therapy session with this clinician.

Encouraging Distance from Cultural Foods

An additional cultural value that one participant felt discouraged from connecting with in therapy was food. Allie noted: "I wouldn't eat Mexican food because for me it was, like, really, bad and calorically dense or whatever and I had a couple of dieticians that were like, 'Oh, well, that food is, like, bad for you.'" With her dieticians validating her avoidance of Mexican food, Allie stated that she believed her healing and recovery was delayed.

Lack of Materials in Spanish for Family

As stated above, Allie also described being denied materials in Spanish that could have assisted her in enhancing her communication and explanations to her grandparents about what was happening for her. By expressing their unwillingness to provide Spanish materials, Allie's treatment providers added to the separation for Allie between herself and her cultural value of language.

Discrimination & Oppression

Another component of therapists' lack of cultural awareness involves the impact of discrimination and oppression. The three aspects of discrimination and oppression include: therapists' unwillingness to discuss discrimination and racism in session, discrimination

occurring in session, and the client observing discriminatory nonverbals from their therapist and other group members.

Therapist Unwillingness to Discuss Discrimination and Racism

Allie described experiences in which her individual therapist was unwilling to discuss discrimination and racism in session:

> She would just stop talking. And she would try and like, or worst is when I would, like, say things to her and she would like, 'I don't think that that's just a thing for people of color. That's possibly something for all of us'… She would invalidate them a lot in a way that I think she meant as actually validating but it, like, I felt often kind of erased me.

When Allie brought her experiences of racism into therapy, she felt invalidated by her therapist. By dismissing Allie's experiences of discrimination, this therapist "erased" her, replicating the trauma that Allie already associated with White people. Allie also found that her therapist was not receptive when she attempted to explain the connection between the oppression of people of color and her eating disorder symptomology. She elaborated by saying:

> I would talk about a lot of political things that were affecting me because I do feel really, my eating disorder is all obviously about control, and I felt like this was something that was really affecting me and I can't control it no matter how hard I try and it's also, like, Anorexia was the way that I was able to make myself feel better or feel like I could control at least something… And, so of course it kicked in when I was feeling really helpless and out of control. And they would, like, I remember with [my therapist], when I would talk about immigration and I would talk about how I was feeling really viscerally upset by a lot of the deportations that were happening underneath Obama… And she would go really quiet, and she would stare at the coffee table in front of me and, like, not

> talk. And I just, I think that there, it was a lot, what I got out of a lot of my treatment interactions was that, it was easier for me to pretend to not be a person of color.

Allie understood that her eating disorder was related to control and that discrimination against people of color left her grasping for control and understanding, turning to her eating disorder as a way to cope. Unfortunately, Allie's therapist appeared unwilling and unreceptive to discussing discrimination and oppression in session.

Feeling Othered and Discriminated Against in Therapy

Melinda noted her experience of feeling othered in therapy. As described earlier, Melinda found herself unable to find a Latinx Spanish speaking therapist who had a specialization in eating disorders. She described her experience when she decided to work with a White eating disorder specialist:

> Even though she seemed to have the knowledge, the not feeling connected to her, the not feeling understood… the struggling with my worth in counseling and her still not being able to understand me. The feeling like I am the other in her office. All of those things, like, weighed more. Like, even if she did have the knowledge, it didn't weigh as much as the other stuff.

"If anything," Melinda recalled, "It was just another place where I felt like the other person." Melinda described feeling like the other person in her school and at work, but it surprised her to have that experience in counseling. While she placed value on finding someone who would help her address her eating concerns, she realized that this was irrelevant if the therapist replicated the experiences of discrimination that she was already experiencing with White people.

Margarita noted feeling discriminated against in therapy when she completed a personality test. She stated:

> And so, I took these personality tests and all of these different tests and she told me that I came up pretty high on the paranoia on one of the tests? Or, like, higher than average. Not that I was, like, pathologically paranoid but that it was higher than average. And then she said something, like, 'Well, that's also really common in minorities.'…I guess I was a little, like, bothered by the fact that being suspicious of other people would be pathologized. I don't know if she was necessarily looking at it that way, it was just, like, a weird thing. A weird comment. And I think it's, like, totally justified.

Margarita felt bothered that the results of her test were pathologized, pointing out that her suspicion of White people was justified. This example cautions against therapists interpreting test results based on White norms and pathologizing adaptive and appropriate distrust.

Observation of Therapist and Group Nonverbals

Three clients described discriminatory and microaggressing nonverbals from their therapists and fellow group members. In conversation around her therapist's lack of understanding, Star recalled her therapist's nonverbals. She stated:

> She was kind of dismissive… She would look really, like, blank and would just… just try to get to the eating part… I think it was just, I started questioning, like, 'Maybe this is not her strongest…' You know? 'Maybe I should go somewhere else.'

Melinda described a similar experience of not feeling understood and recognized this lack of understanding from her therapist's nonverbals. She recalled:

> It's something that is normal in my culture and… I think offended is the right word. I remember just being like, 'No, no, no. You don't get it. This is what I'm trying to say.' And even when I explained myself, there was something about their nonverbal cues that gave me the understanding that they still didn't get it.

Allie also recalled a vivid example of her therapist's confusing reaction to her arrival to session:

> I felt that she was, I felt like she was really messing with my mind, playing mind tricks with me a lot of times. Because she would also do things really subtly where she would, like… I knew her lunch break was right before my session and so I think as a way of trying to be considerate of me, she would try to, like, hide her food. But there was one thing that she would do, and I would get there early so I would, like, see it happen but she would always like switch her drink to, like, a diet option when I came into the room and I don't know why that happened, but it left me feeling really, like, strange about the situation.

Allie also recalled observing the microaggressing nonverbals that she witnessed in her group therapy group. She recalled discussing the killings of Black men by police in a group therapy session, hoping for support on how these brutal acts were impacting her and her disordered eating. However, the response was not supportive. She noted the silence and discomfort she encountered, as group members shifted in their seats, avoided eye contact, or left the room.

These detailed memories in therapy of discrimination, dismissal, and invalidation demonstrate how strongly these experiences impacted the participants. Many of these interviews were conducted 5 to 10 years after termination of therapy services. Yet, participants could vividly recall their therapists ignoring experiences of oppression outside of therapy and replicating oppression inside of therapy. To revisit Allie's powerful words, it was easier for her to pretend to not be a person of color because her therapist would validate her more. Allie, and others, felt required to disconnect from their identities in order to feel validated by their therapists.

Lack of "Existence" of Anorexia Nervosa

Based on the accounts of participants, it appears that treatment providers did not understand the lack of "existence" of Anorexia Nervosa in the worlds of some of their clients. While we will explore this concept in the second part of this essence of the phenomenon, the assumption that those in treatment for Anorexia will understand what Anorexia is impacted several participants' experiences. Star, Melinda and Allie all noted feeling undirected by their therapists in treatment, compounded by not feeling informed about what treatment would look like. Star recalled:

> She was just was sitting there and she didn't validate me and would nod her head the whole time and I'm just like, 'I don't know what I'm supposed to do.' Like, 'I need your guidance.'

Melinda's statement echoed Star's concerns:

> I remember saying, 'She should know.' Like, 'She knows. She would tell me if I'm not any better.' I think I just went in with this expectation that she would just tell me what to do too. Kind of like when you go to the doctor and they're like, 'Okay, this is what you have, and this is what you're going to do.

Allie also noted feeling confused by therapy, commenting that her symptoms worsened while in treatment:

> And I also felt really… confused, I think at that time. I felt like maybe I was wrong for feeling this way. I also felt like, I would always leave the sessions feeling very, like, I guess worse about myself in some way. And then, I did, I started to look into, after that, I wasn't seeing any real progress with her.

Participants' experiences of feeling confused and undirected in therapy speaks to an assumption made by providers of universal knowledge around the existence of Anorexia.

Feeling Disconnected from Latinx Culture

The next section focuses on the second facet of the essence of "Isolation." While the first side of "Isolation" focused on the experience of feeling disconnection from mental health professionals, the other side of this essence centers around the experience of feeling disconnected from Latinx culture. As the subsequent findings move towards experiences of being disconnected from Latinx culture, note the significant overlap with the power and privilege of Anorexia Nervosa treatment being a White dominated field and the themes of not feeling connected to Latinx culture. These two areas are inextricably linked and compound upon each other to create the experience of isolation that was described by every participant of this research project. The three major themes of meaning for this part of the first essence include: identities, values, and stigma. These three components contributed to the experience of isolation for these seven Latinx participants in their experiences of Anorexia treatment.

Identities: Not Belonging Anywhere / In-Between

The first theme of meaning under this facet of the essence of isolation includes three major areas that participants brought up around feeling disconnected from their identities: feeling disconnected from cultural identities, presenting as "light-skinned" or "White-presenting" and not presenting as the Anorexia Nervosa stereotype. These components of the identity theme overlap significantly but have been separated in order to capture the unique experiences of participants.

Feeling Disconnected from Cultural Identities

All seven participants discussed feeling disconnected from their cultural identities in their interviews. Star pointed out:

> I think it was important because for me at least during my severest time in Anorexia… I had lost everything. Like, I had lost all of my identity. Like, it didn't resonate with me to be Mexican anymore and I wasn't… like, it's kind of cliché but I wasn't… I wasn't Mexican enough, so I didn't… it didn't resonate anymore. And I also wasn't… I was also of color. So, it's like, but you are? You know? It's kind of weird to explain but during that time I felt like everything was off. Like, I wasn't… I was like a shell of what I used to be. Like, I lost all of my identity. I wasn't… I didn't identify with, like, my family and my friends that were Mexican, Latino, Latina. I didn't identify with my White friends either. Like, I wasn't anywhere in that spectrum. I was just like, I don't know who I am. I was so lost. Yeah. Definitely not who I am now.

Star's experience of not feeling Mexican enough but also not identifying with her White friends speaks to the isolation she experienced, and her belief at the time that she had lost all of her identities.

Three participants brought up the experience of feeling disconnected from their multiracial cultural backgrounds. Allie recalled reading a statistic stating that biracial women have a high rate of Anorexia diagnosis. "Which I guess makes sense," she followed with. "Two worlds split." Angela noted:

> When I'm talking to other people of, like, mixed cultural backgrounds or just mixed racial backgrounds or whatever it is, of sort of feeling this, 'you don't belong in either space' and just this sort of this push-and-pull of kind of feeling like you're in-between.

> Of, like, 'Oh hey! I don't really have full understanding from this group but, like, I'm also not fully accepted in this other group either.'

Margarita also described biracial identities as an important frame of reference in understanding her experiences. "There's this certain element of color blindness in Mexican dialogue about race," she said. "Or lack of dialogue around race, like, 'We're Mestizo, we're all Mexican." However, she noted the tension that this created for her with her mother presenting as a light-skinned Mexican and her father presenting as a dark-skinned Mexican. While Margarita did not feel as if she fit into "one box or the other," she described her parents not identifying as a biracial couple, because of the emphasis on a collective Mexican identity.

She also described feeling that race in the United States, other than identifying as Black or White, is rarely discussed. Pointing out her experience of feeling out of place, Margarita stated, "I know I'm not Black and I know I'm not White. I'm in this weird limbo that no one can define, nobody knows. I just felt, like, in no man's land, kind of thing."

Margarita connected this experience of feeling out of place with her struggle with disordered eating:

> There wasn't really any models to turn to in terms of, 'What does it look like to be a Latina in this community?' …I would say that that definitely impacted body image because it was, like, I was not the body. (Laughs) Like, I didn't have the body or the appearance to be, like, visible. To be, like, I did not exist. Essentially. Nobody liked me. Because my mom was White, she's Mexican but she's a White Mexican… she's very fair skinned. She has straight, like, very, she has very light hair. She only has to shave half of her legs. And I was, like, this really hairy brown girl with curly, unruly, frizzy hair, in a sea of White. And so, I constantly felt, like, I grew up feeling like this aberration… I

> already knew I didn't fit in. Like, it wasn't even, like, like I needed… there's not anything I can really do to fit in. I stood out that much. I remember trying to be friends with, like, the South Asian girls because I thought they would maybe, like, accept me because I looked more like them and that was not the case. So, that was hard.

Margarita described growing up and knowing that she could not "fit in" with White culture. Instead, she described her eating disorder as a way to take up less space and become invisible in a White world. She noted not feeling seen as a "brown girl" in a White world, adding that she would only receive interest from those around her when they were curious about "this weird exotic specimen." "But after that point," she recalled, "once people can put a label on you, like, 'Oh, you're from here,' like, the interest stops, and people don't actually want to know you as an individual."

Melinda described immigrating to the United States and the experience of acculturative stress as impactful in her disconnection from her identities. She commented that her symptoms of restriction "kicked off" when she arrived in the United States, with a desire to fit in and meet U.S. beauty expectations. "Which is kind of the position I was in," she noted, "between, 'I have to look like Miss Colombia,' versus 'what does the ideal body look like in the U.S.'" Melinda's account sheds light on the push and pull she felt in striving to meet the unrealistic expectations of beauty in her home culture, as well as the U.S. culture.

Allie also reported her desire to fit in somewhere, in the context of a predominantly White university, and how this contributed to her experiences of disordered eating. She stated:

> [My university] was super, super White and I'm an actor and I was trying to, I had never grew up really aware of my race, being in [my hometown] everybody kind of looks like me. And then I moved to the Midwest and everything was suddenly so different, and this

> culture was so different and I always like, the butt of these jokes that I didn't even, like, realize? People would make these racial jokes about me all the time and I didn't, like, I didn't know what to do with that, that's the first time it had happened. And we were, my best friend and I were told that we weren't going to be able to be cast in plays because she didn't know where to put us on stage… And that just added to my sense of, 'You are othered,' 'You are too much.' And so, I think, in a lot of ways I think part of my eating disorder was, I don't like to say trying to become White, but trying to make myself fit somewhere.

Maria vividly recalled receiving cards when she was in the treatment center from a Latinx friend, noting how powerful it was to have her first friend who identified as Latinx. She stated:

> She started writing cards to me while I was in the hospital. Just, like, letting me know that she was praying for me. Which I thought was really sweet, because she was my first Hispanic friend… Because I lived in the middle of nowhere. [The city I was in] doesn't really have a big Hispanic population… I went to [this university] where I didn't have any Hispanic friends either. So, I had to learn how to, and this has been something I've been able to get back since I moved here, but I had to learn how to White-ify myself when I was in college. So, I think I was accustomed to it. Having to restrict myself of my deep accent, my main roots, if you will… It was either, like, I did that or I had no… like, the Latinas, they were, like, hardcore trying to get me to join their Latina sorority, but I didn't want to because I wanted a traditional experience and so I joined the regular sorority and the Latinas, like, didn't want to be my friends anymore… I had to choose between the Latinas or, like, J Crew. And what is an 18-year-old going to do if she wants to fit in? She's going to learn, like, all about wearing pea coats, and J Crew and, like,

> country music which I had no concept of. And Shania Twain became, like, our anthem, not Shakira. So, living in [this state] was, like, 'Well, I'm just continuing being White and that's okay.' But having Priscilla, like, my first, like, Hispanic friend was so comforting. Because I could talk to her in Spanish. And because I also, I did belly dancing… That was very healing for me. And within my belly dance class, I met a girl who was from Mexico, so she was my other Hispanic friend, so I had two Hispanic friends. And that… made me feel at home.

This account from Maria captures her college experience in which she felt she had to choose between the "traditional" experience, having to "White-ify" herself, or connecting with other Latinas. Currently, living in her hometown, working with a Latinx therapist, Maria feels that the experience of being connected to her cultural identities has been a pivotal part of her healing from disordered eating. She said:

> And I can totally be my silly, obnoxious, Hispanic self if I want. Speak with a [hometown] accent and people will understand me. And listen to Spanish music and people will understand me… It's like a coming home and it's also, like, that cultural connection. Now I've got, like, all of the elements in place. Now I've got my therapist, I've come to terms with the medication I'm taking. I'm back home. I'm in [my hometown] again. I'm Hispanic and not White again.

"White-Presenting"

Three participants described the experience of being "White-presenting" and how their light skin color impacted the perceptions of others around their identities and their symptoms of Anorexia Nervosa.

Angela acknowledged being aware of the way that she presents when she shares her story of Anorexia as a light-skinned Latina:

> So, I am a light-skinned and, like, often times a White-presenting Latina… I do know that a lot of times, like, the… I guess stereotypes around eating disorders, like, 'Oh, that's, like, a White girl's disease,' or like, 'Oh, that's for these White suburban women' or whatever… It's a little bit of an added layer for me, especially when I'm trying to share my story and that space with other people of color and other Latinas especially, it's just, like, I'm mindful that when I tell this story I very much look like the stereotype?

When asked about experiences of discrimination, Ani also emphasized to the primary researcher the privilege they experience as White-presenting:

> You have to understand that I am a different, a different level of privilege because of, of how I look. Like, I'm still, I'm White-skinned, I'm very fem-presenting, like, I don't look different? I… I didn't, I didn't face a lot of the issues that I know a lot of other people with eating disorders, specifically people of color with eating disorders face.

Ani noted not looking "remotely Mexican at all" and that the White girls on her floor in the treatment facility appeared surprised when their family would come to visit. "Some of the other patients… saw that… I come from brown people?" Being light-skinned also impacted the way in which Allie was viewed by members of her treatment group. When she spoke up about instances of racism against people of color during group, members appeared confused about why she would bring this up in group therapy. "I'm light-skinned Latina, and I think that there was a lot of people who couldn't understand why I was feeling so much empathy for other people of color if, like, I pass as White." The experience of presenting as light-skinned in treatment

facilities, therapy groups, and even in these interviews, impacted the way in which participants believed they would be understood and viewed in treatment.

Not Presenting as Anorexia Nervosa Stereotype

Two participants described not presenting as the Anorexia Nervosa stereotype. “My body wasn’t as thin as the whole stereotype of having Anorexia,” Melinda stated. “I was definitely curvier.” Allie talked about her experience that her symptoms were brushed off by doctors because she identified as Latinx. Calling her “a curvy girl,” Allie recalled treatment providers who dismissed and invalidated her experiences.

Values

The next section will address the experience of being disconnected from Latinx values while engaging in Anorexia treatment. The three values discussed include language, food, and family.

Language

Two participants mentioned a disconnection from the word “Anorexia” in their languages of origin. Each described the terms and symptoms of Anorexia being inconsistent with the Spanish language. As Allie stated:

> I mean, the word for Anorexia in Spanish... it’s a derivative of the English word. It’s not a Spanish word. So that just, I think in and of itself, shows how not a part of our world it is. It’s, like… and so my grandparents really had no idea.

Angela also described her mother dismissing symptoms of Anorexia, partly due to a disconnection with her language. “I think,” Angela said, “Culture and having a language for all of this stuff, even like medical terms and symptoms or whatever, stuff like that, she didn’t really have an understanding of what it was?” While Allie and Angela both described a disconnection

from the word "Anorexia" from their cultural language, these examples also speak to a disconnect between an understanding of Anorexia and their families, which will be discussed in the following sections.

Food

Melinda described her experience of feeling disconnected from important cultural foods. She stated:

> Food is such an important thing in our culture too… Food is a big deal in our culture, just the way that we, I mean, you think about it, when there's people visiting you always have to have, like, a specific special meal or so many things around food. I think even coming here to the U.S. and how important it is for me to find where the Colombian restaurants are. And eating it and feeling like I'm at home and how important it is for me that it's authentic Colombian food. Or even when my mom comes here to the U.S. and she cooks for us. There's something, there's so much warmth that comes from it for whatever reason… But to get here to the U.S.: I'm away from my family, away from my culture, and then even stepping away from food, which is another piece of my culture, it was even more isolating.

Melinda described the experience of acknowledging the cultural value of food, while also experiencing disconnection from it, noting the isolation that followed as a result of stepping away from cultural foods.

Family

The next section focuses on feelings of disconnection from the value of family, exploring feelings of isolation from family, as well as family barriers to involvement.

Feelings of Isolation from Family

Five participants described their experience of feeling isolated from their families throughout the treatment process. Four of the five stated that attending Anorexia treatment separated them from their families, causing feelings of isolation. These participants all described disapproval of treatment or lack of understanding around the necessity of treatment as key barriers to family involvement. Participants described the pain they experienced from feeling separated from their families. Star recalled, “I felt really alone and really hurt… because I thought my family just didn’t want to help me. Like, I thought they were just being really mean and, like, ‘How dare they let me go through this alone?’”

Angela discussed feeling isolated from her family as a result of their disapproval. She recalled her parents not approving of therapy, stating that she had to fight to even get in the door to treatment. Margarita also described feeling isolated and separated from her parents, who did not understand why she could not talk to them about her concerns. Allie, on the other hand, described not feeling as though she could talk to her mother about what was going on for her. She recalled, “And I couldn’t talk to, my mom is the person that I talk to every day but I couldn’t talk to her about this and so it felt really isolating.” All three of these accounts point to the conflict between having to choose between treatment or receiving support from their families, leading to experiences of isolation.

Melinda also described the experience of being physically distant from her family during her time in treatment. She noted looking for a therapist who could provide a piece of the familiarity of family. “To feel less isolated,” she recalled.

Barriers to Involvement

Next, barriers to involvement for families will be discussed. External barriers to involvement will be explored first, followed by internal barriers to involvement. Prior to discussing these areas, it is important to consider the awareness of participants of the differences between their families' involvement and White clients' family involvement. Star noticed that other clients in her treatment center, who identified as White, had the privilege of having their families constantly involved in the treatment process. She stated:

> They never made me feel like at outcast or anything, but I myself felt…. Like, they would be like, 'Where's your mom for family therapy?' And I'd be like… (Sighs and Laughs). And I never knew what to say. I was just, like, 'She's not coming.' And they would never understand because they were… it was different, you know?

As seen in previous sections, this appears to be, in part, due to therapists not offering family therapy to these participants or offering culturally incompetent family sessions that deterred families from engaging. However, therapists may also not have considered the privileges that a client and their family have for being able to engage in family therapy. By exploring these barriers to involvement, an understanding of the privilege of family therapy may become more apparent.

External Barriers to Family Involvement

Distance, family responsibilities, financial obligations, and immigration status were described by participants to be four external barriers to family involvement.

Distance

Two participants noted physical distance as a barrier to their families' involvement in their treatment process. Melinda and Maria both described being away from their families. When discussing her family not being involved in family therapy, Maria stated:

> And I think it would have also been really helpful, obviously, if my parents were local but, unfortunately, they weren't so they couldn't see me at all. Like, my mom saw me when she dropped me off? She flew up to [my city] to check me in to the hospital clinic. Because I checked myself in. But then after that, that was it. So, it was all long distance. So that was also super hard for them in that regard. And that's not to say that they weren't there for me. They totally were. I would call them on a daily basis.

Maria described her parents being there for her as much as they could, supporting her through daily phone calls, but pinpointed distance as a main factor for her family not being able to be involved in treatment. Interestingly, later in the interview, she described being near her family and in her hometown as a large part of her healing process from Anorexia. She stated:

> It's where I needed to come back. Like, at that point in the recovery journey 5 years ago, I, I just needed to be back with family and friends. Because all my friends are here, all my family is here. And you kept saying connection, I needed that connection, those roots. And I was able to come back and be with aunts, uncles, nieces, cousins, surrounded by love.

While Maria's family was not able to be involved during her time in treatment, it appears that being connected to her family and friends was significant in her recovery.

Family Responsibilities, Family Obligations and Immigration Status

Star described family responsibilities as a barrier to her mother's involvement in treatment. She stated, "My family was never involved… because my mom had to take care of my siblings… And not to say that my mom was never there because she was there… As much as she could have. Which I appreciated."

Allie discussed financial obligations as a factor in her parents' ability to support her through treatment. She said:

> But I also think that we, my family in particular, I don't know, I think that maybe if I would have talked to them at the time, that they would have figured out a way to find me treatment, but I just didn't want to be, like, a burden on my family when I knew that they already had, like, other financial obligations.

Allie described her awareness that she would place undue financial stress on her family by requesting treatment. Lastly, Star described her mother's undocumented immigration status as a barrier to her ability to be involved in treatment.

Internal Barriers to Family Involvement

Two internal barriers to family involvement discussed by participants included preference for religion and fear and denial.

Preference for Religion

Angela, Maria and Margarita discussed their families' preferences for religion over therapy as a barrier to family involvement in treatment. Angela stated that her mother's religious preferences came to mind when her therapist suggested a family session. Explaining that her mother identifies as Catholic, Angela added:

> She's essentially, like, against therapy. She doesn't really understand it. She thinks that any problems that you have should be prayed about.

Margarita voiced a similar sentiment from her family when people shared their concerns about Margarita's health to them. "A lot of times my parents said they were going to pray for me," she recalled.

Maria noted her mother's reconnection with her religious beliefs during her time in treatment:

> She actually went back to church and praying regularly? When I was sick. So, for her, it was, like, a big piece as well and helped her and she would pray for me and my grandmother would pray rosaries for me. So, like, my mom will tell you, she still says she's thankful to, like, Mary, she would pray, she believes in the power of prayer and the healing prayer. So, to this day, she's, like, 'I prayed and thank Mary every day that She created a miracle and gave you a second chance.' I think that that faith piece is an important element.

These accounts emphasize the belief in the power of prayer and religion for the families of these three participants. While they acknowledge family preference for religion as a barrier for involvement in treatment for some families, they also bring up an important point about the perceived dichotomy between mental health treatment and leaning into religious values during times of need.

Fear and Denial

Star and Allie both brought up fear of the unknown and denial of the problem as barriers to their families' involvement in treatment. Star brought up the fear that her mother experienced

around her daughter's illness when she stated, "My mom… was almost too afraid to just face what was going on. And she still doesn't understand to the day." She elaborated:

> And I understand why she couldn't be there. It was so hard for me that I can only imagine as a mom to hear that your daughter is dying and she has to go through all that stuff, how hard that must be. I saw her cry and I understand. I couldn't fathom if that would happen to me. I mean, now I could because I know what to do but if I were her.

Allie described her family's worry and confusion about what was happening leading them to "squash" concerns around the disorder. "It's not really a problem," Allie recalled them saying, "You're fine." She recalled that when she was battling Anorexia, she discussed with her family the possibility of attending treatment. "They pretty much flat-out refused," she recalled. "I think they blamed financial reasons, but I think what it truly is, is that they didn't want to admit that it was a real problem." Allie's account brings up fear, confusion, and denial as significant factors in accessing treatment and family involvement. The mixed emotions to Anorexia treatment from parents lead us to the final component of the experience of disconnection from Latinx culture: stigma.

Stigma

The three areas that will be discussed in the last section of this essence include stigma around mental health, Anorexia not being discussed in Latinx communities, as well as families not being informed about Anorexia and not understanding the meaning of an Anorexia diagnosis.

Stigma around Mental Health

Three participants mentioned a stigma around mental health concerns and treatment for their Latinx families and communities. As Melinda stated:

> That comes from the whole stigma that there is in, in the Latino culture with mental illness? And for me to accept that I had an eating disorder was accepting that I was being, that I had a mental illness and to accept that I had a mental illness meant that I was being weak. Yeah. I think it's all of those components. I think it was also being… moving here to the U.S. and, like, here is another reason why I'm the other person because I'm a minority here.

She elaborated by stating, "I remember strictly the word 'crazy' being used in Colombia if you ever had to go see a psychiatrist or a psychologist." Melinda's description brings up two significant points about the stigma around mental health: the perception that having a mental health concern means that you are weak or crazy, as well as the experience of being "other" as a minority in the United States being compounded by having a mental health concern.

Eating Disorders Not Talked about in Latinx Communities

Six of the seven participants indicated that eating disorders were not talked about in their communities or were viewed by those around them as "normal." Star and Angela voiced similar concerns, stating that eating disorders were not talked about in Latinx culture. "So, it's sort of become this invisible thing that a lot of people have to deal with," Angela noted. Allie further noted her grandparents not believing Anorexia existed for them. "This couldn't be happening," she recalled them saying. "That's not something that we get, that's something that White people get." Maria noted her family not understanding what Anorexia was because it was "not something that was ever talked about."

Melinda and Margarita both talked about disordered eating as something that was viewed as normal in their families and communities. Melinda stated:

> I thought that what I was doing was normal. Because growing up, I saw everybody in my family doing it, the whole restricting and then we just call it dieting I guess? And I saw family members going through surgeries, like, multiple types of surgeries in order to get that body that they wanted. I remember dieting a lot. My mom didn't put me through any diets but she was put on a lot of diets by her doctors? Throughout her life. I can remember going to the dietician appointments with her and everything. And just kind of picking up on some of that stuff.

Margarita described a similar normalization of weight-loss in her family:

> And people will call someone, like, *flaca*, like, skinny, or *gorda*, like, fat, as a term of endearment but people will, like, also be, like, 'Oh, you've gotten too skinny,' or 'Oh, you've gotten, like, you've gotten too fat.' Or, like… I remember my mom, my mom was, like, my mom dieted on and off, she never said she was fat or anything really, like, self-hating, you know, she was never, like, 'I need to lose weight, I'm so fat.' She was never self-deprecating… But I remember she would have these random weeks where she was, you know, eating bland food like cottage cheese and crackers and she would have a little thing on the fridge that had her little diet meal plan and she would do that for a while. And I remember her friends, and her friends are Mexican and, like, her friends coming over and being, like, 'Oh, I can't have this because of my diet,' and I remember thinking, like, diets sound awful (Laughs).

On one hand, eating disorders, particularly Anorexia, were not talked about in the families and communities of the participants. On the other hand, dieting and weight loss were seen as the norm.

Family Not Informed about Eating Disorders

Eating disorders not being talked about or being viewed as normal in Latinx families and communities closely relates to the final theme of stigma. Six participants described their families not being informed about eating disorders or not understanding the meaning of an Anorexia Nervosa diagnosis. As Star stated:

> They, like, didn't know about that stuff. That stuff didn't exist, you know? They knew nothing about it. Like, in their world, it wasn't in their world. So, when I started going into treatment, it was weird. It was like, they knew I was in treatment for something, but they didn't know for what.

Angela described her mother not being able to understand, especially in the context of their own experiences:

> She didn't really understand what it was? Or how to talk to me about it? So, it kind of became, like, an unspoken thing… between us. And so, I think, like, that was something that was hard. Especially because, like I said, she was also, like, very petite, she's never been larger than, like, a size 2 in her whole life?

She further stated:

> One, I think eating disorders aren't even talked about in like… honestly in most immigrant cultures but, like, especially in Latino culture. I feel like a lot of, and this is something that even talking with friends is seen across the board of, like, Latina moms don't really know, like, what an eating disorder is or how that manifests? And so, I think it was just, yeah, kind of the same thing with her. Like, she didn't, like… when she was growing up, she, like… the only time she would go without eating food is because they didn't have money to eat food?

Not only were eating disorders not discussed in her community, but Angela perceived her mother's own body type and relationship with food as impactful in her understanding of Angela's disordered eating.

Three participants mentioned families not understanding because of a focus on the physical side of the eating disorder. Star recounted her mother saying, "I don't understand. Why don't you just eat?" Allie recalled a similar experience: "They just didn't understand why I wouldn't talk to them about it or… why I couldn't just eat." Maria stated:

> They didn't quite understand that it was, like, mental or emotionally linked… they could only see the physical piece? Like, their daughter is skinny. They didn't understand what Anorexia was. And truthfully, like, it's not something that was ever talked about, so to them… it was like, 'Oh, an eating disorder. She just doesn't want to eat.' That was what they thought. She just doesn't want to eat. So, they didn't quite understand, the piece that there's an emotional or psychological connection to it at the beginning.

Maria elaborated by stating:

> They didn't understand. They didn't know, how do you explain to a parent what Anorexia is? Let alone, like, a Latino family that had no concept of an eating disorder except that, well, she's not eating. Like, that's all that they could focus on. So, to have me bring up the fact that it could be, like, you know, emotionally or psychologically, that's a taboo topic to talk about to begin with!

These descriptions emphasize Anorexia not being a part of the world for Latinx families and, therefore, not being understood. In an attempt to understand, most participants' families focused on the food refusal, acknowledging the physical piece of the disorder without having the knowledge about Anorexia to grasp the emotional side.

All in all, participants described an overall sense of isolation, describing feelings of disconnection from mental health providers, as well as feelings of disconnection from Latinx culture. Throughout the treatment process, participants described feeling disconnected from their therapists, particularly White therapists with little knowledge of their cultural experiences and values. Simultaneously, participants noted feeling disconnected to their Latinx cultural values and identities.

Costs of Culturally Incompetent Treatment

To supplement understanding of the first essence, it is important to discuss the costs of culturally incompetent treatment. Three costs of culturally incompetent treatment include early termination, assimilation to White culture, and undertaking the recovery process independently.

Early Termination

Five of the participants recalled ending treatment with their therapists early. Reasons for early termination ranged from belief that the therapist could not relate to their experiences, comparisons of White therapists to Latinx therapists, feeling shamed by their therapist, and not feeling that rapport was developed. Star recalled not liking her therapist from the first session, noting that she was "boring." She added that she was comparing this therapist to her Latinx therapist, an emotionally expressive clinician with whom Star shared a powerful connection. After the first session of therapy, Star decided not to go back.

Margarita also recalled only seeing her White therapist once before ending services, noting that her therapist made her feel shamed for the way the disorder could impact her family. Melinda, similarly, described a lack of rapport building in her first session of therapy and her experience of feeling othered in the therapy room, leading her to discontinue therapy after four or five sessions. Allie recalled attending sessions for a week or even a month before she stopped

going. Ani also talked about leaving treatment earlier than recommended. “It would have been nice to stay,” they stated, “but at the same time there is an immense amount of labor that you have to do when it comes to this kind of back and forth between the treatment facility and your people. And trying to manage that and balance that while you’re trying to heal yourself is really exhausting and it’s really overwhelming.”

Assimilation

An additional cost of culturally incompetent Anorexia treatment was the need for participants to assimilate to White culture to fit in. Allie and Maria both voiced this concern. As Maria stated, “Well, I’m just continuing being White and that’s okay.” Allie recalled that it was easier for her to pretend to be White than to be a person of color. “They would talk to me more, they would treat me more, validate me more,” she stated. Participants’ assimilation to White culture was an adaptive and necessary response for surviving in treatment settings where their cultural experiences were ignored, dismissed, and invalidated.

Undertaking Recovery Process Independently

Angela, Melinda, and Allie all described having to undertake the recovery process independently or believing that their treatment would have taken less time due to the culturally incompetent treatment that they received. As Angela stated:

> I think knowing that when you’re working with people of different backgrounds, like, they could possibly benefit from a more… like, questions that relate to more, like, family background or, like, a whole level or history or whatever it is. I think that could have helped me to get that sooner rather than… luckily, I was able to go to the talk and have that experience but the fact that I was in therapy multiple years and never really had that? I think kind of showed that, like, I wish that would have been brought into it.

The opportunity to go to a talk hosted by Nalgona Positivity Pride gave Angela the tools to consider how her cultural background impacted her eating disorder, but she lamented having attended therapy for years and never having therapists bring this into treatment.

Melinda also described her frustration that her treatment could have taken less time if she were provided appropriate treatment:

> It's sad but I kind of had to learn on my own, like, in my own career in stuff, that's when I learned all of the eating disorder stuff more. And I was able to understand more about myself. Back then, I think it would have taken me less time to get to the place of feeling at peace with my body and with food and obviously considering that this is an every-single-day kind of work… with the world that we live in, but I think that it wouldn't have taken me so long to get to this place.

Allie became tearful when she reflected on having to do "a lot of the heavy lifting of getting better" on her own:

> I feel really, like, it's… it is making me feel a little emotional because I feel really angry for the people that, like, kept my younger self from… I could have been recovering several years ago.

She recalled being able to piece together her own treatment plan when she finished with therapy. "But I really, really wish that I wouldn't have had to do that on my own," she stated. "Mostly it was… a lot on just me and getting to, having to spend a lot of time and a lot of really hard work trying to self-examine and figure out how to get better when nobody else was helping." Allie's words provide a warning about the costs of culturally incompetent treatment; they also remind us of the experience of isolation in having to complete the recovery process independently. If

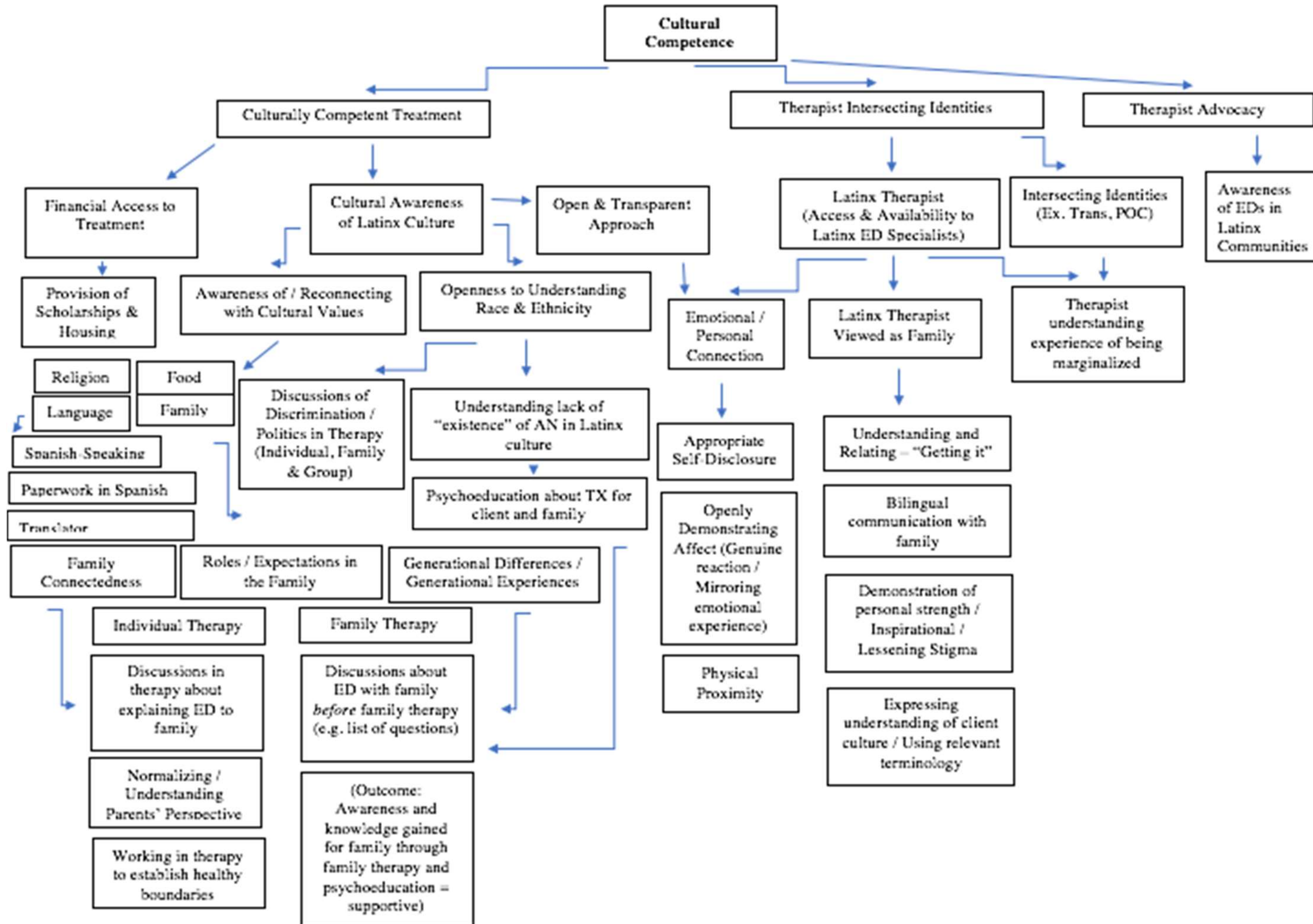
Latinx clients are disconnected from treatment providers and often isolated from their families during their time of need, who can they depend on for support?

Essence Two: Cultural Competence

The second essence of the phenomenon pertains to the experience of culturally competent treatment for participants. Disappointingly, this essence of the phenomenon is significantly less developed than the essence of isolation. Participant accounts often attested to experiences of being disconnected from mental health professionals, rather than feeling supported with cultural competence infused into treatment. However, this essence offers the opportunity for imperative improvements regarding culturally competent treatment for Latinx clients in Anorexia treatment and is, therefore, an extremely important area for treatment providers to consider when determining their abilities and competencies in providing treatment. See Figure 2 for a visual representation of the second essence of the phenomenon.

Figure 2

Essence Two: Cultural Competence



Therapist Intersecting Identities

Therapist intersecting identities played a significant role for participants when reflecting on experiences of culturally competent treatment. This section will explore participants working with Latinx therapists in treatment, as well as participants working or being supported by therapists and staff with marginalized intersecting identities.

Latinx Therapist

This section explores the way in which Latinx therapists, through their identities, actions, and words, provided a culturally competent therapeutic experience for participants. As Melinda stated:

> I think that it was so important for me to see… just another, just a provider that looked and sounded like me. There's something about that that really stands out to me. I don't know if it's the comfort that came with that, I don't know if it's the, just the place, where I was at the time, but that was a big deal for me. It was a big deal to see a provider that… that understood me. Not just because of books. Not just because of research that they've read but, like, them truly understanding what it was like to be a Latina in the U.S. That was a big deal for me. I think that there's a lot of empathy that can come from studying, from reading, but I think that there's a different level of empathy when you've gone through it yourself.

Themes of meaning for this area include therapists' ability to understanding Latinx culture, incorporating cultural values, as well as being able to understand and discuss experiences of discrimination and oppression. Table 3 provides a summary of the participants who had the opportunity to work with a Latinx therapist and if their therapist specialized in eating disorders.

Table 3

Summary of Participant Work with Latinx Clinicians

Participant Pseudonyms	*Latinx Therapist*	*Latinx Therapist's ED Expertise*
Star	Yes	Yes
Angela	No	-
Melinda	Yes	No
Allie	No	-
Ani	No	-
Maria	Yes	Yes
Margarita	No	-

Switching to Working with Latinx Psychologist

Star was the only participant who described being switched to a Latinx psychologist after beginning treatment. She described the treatment director determining, "I think it will work better if you're with someone like a Latina woman." The treatment center concluded that this switch would meet her needs because, firstly, the therapist would be able to better communicate with Star's mom in family therapy and that the therapist would know more about Star's culture. As described in the following sections, this switch provided a profoundly healing experience for Star and points to the need for access and availability to switch therapists as a component of culturally competent treatment.

Latinx Therapist Communications with Family

Star noted the importance of her Latinx therapist being able to communicate with her mother. “It was really nice that my psychologist was Latina,” she recalled, “Because she would talk to my mom in Spanish and… my mom only speaks Spanish.” By working with a therapist who was bilingual, Star was able to have her mother included in her treatment process.

Therapist Understanding and Normalizing Parents’ Perspective

Star also described her therapist’s ability to understand where her mother was coming from. Star recalled, “She was like, ‘Yeah, I know. This stuff doesn’t happen. Or at least isn’t talked about.’” Indeed, instead of drawing additional boundaries between Star and her mother, based on their separate understandings of the disorder, Star’s therapist encouraged her to understand her mother’s perspective. Star remembered her therapist saying:

> Mama comes from somewhere different… She doesn’t come from a society that glorifies, like, being thin. You don’t talk about eating disorders.

Star’s therapist also expressed her understanding of her parents’ hyper-focus on Star’s disorder, even after she experienced significant improvement. Star explained:

> My mom, I remember she went to therapy and she was just, like, so disappointed that that happened to me. Like it was my fault… I remember that session, in particular… she was so let down by me. And then for a long time, that was the only thing she could focus on. Like, I got back to school, and I was doing really well. Once I got back I started doing so well. And… all she could focus on was, like, I don’t know… It would always go back to, like, ‘You were in treatment.’ You know? Like, ‘You almost killed yourself.’ Like… everything I would do if it was really good, if I did really well or I got a really good job, it was like, ‘Oh, yeah, but this happened to you.’ And I was just, like, ‘What?’ And that

> was something my therapist was like, you know, 'That's going to happen.' Like, 'They're going to focus on that a lot.'

By normalizing Star's parents' perspectives, her therapist upheld her cultural value of family connectedness, understanding that in Latinx communities Anorexia Nervosa does not exist.

Discussions about Roles and Expectations in the Family

Star recalled being able to talk to her Latinx therapist about the pressure she experienced in being the oldest child in her family. "We would talk about that a lot," Star recalled:

> How I was the oldest and first generation and I was also, like, a 'perfect,' quote-unquote, student and daughter. And she would always be like, 'You know how they put you on this pedestal and then you do something little, like, especially if you're a woman, they just go hard on you.'

Star's therapist expressed her understanding of family roles and expectations in Latinx culture, drawing on her own life experiences to normalize what Star was going through.

Working to Establish Boundaries in Familial Relationships

Star and Maria both discussed working in individual therapy with their Latinx clinicians to establish boundaries in harmful familial relationships. Star noted having to "cut a lot of people off" during her time in treatment. When discussing her work with her therapist who identifies as Latinx, Maria recalled:

> It's cool, like, she gets me, she understands me, she's also Hispanic and grew up in, like, a deep Hispanic family. So, she understands the nuances of what a typical, like, Hispanic dynamic can be. For better or for worse, she understands how, like, how immersed the family can be, so, like, enmeshed, and just, she also, like a big piece for her with me, a big challenge has been separating myself from my family. Not, like, in a bad way but just

> trying to lead a life, like, separate and independent. From their watchful eye, almost. Because she's, like, she recognizes that I'm just all about my mom, my dad, do I have their approval? I, even to this day she, like, has me on that regiment of, like, you are not to go to your parents' house every day, you have your own apartment for a reason. You, like, can go to your parents' house, at the time it was just to do laundry, but now I have my own facilities. But she was, like, 'You can only go to your parents' house once or twice a week, tops, and if you're going to talk to your mom every day, it's not going to be, like, you're not going to allow her to be, like, this emotional…,' like, not leech, but she can be a little bit of an emotional leech. She has to teach me how to be independent while still being incorporated into my family, obviously, but, like, teaching how to, like, not rely on family. 24/7. To not have my identity just be that. Which is so easy for me to do and get lost in.

Maria's account emphasizes the careful balance between being independent, while still being incorporated into her family. Working in individual therapy, Maria and her therapist were able to discuss navigating her own self-care and her care for family. This conversation appeared to be even more impactful for Maria because of her therapist's identities and, therefore, her ability to understand the nuances and dynamics of a Latinx family.

Physical Proximity

Melinda noted the importance to her of her Latinx therapist's demonstrated comfort in being physically close to her. She stated:

> I had to learn a lot of things when I came to the U.S. Like your whole personal bubble kind of thing (Laughs). In the Latino culture, at least in Colombia, we don't need that much space between one another. And when I got here I kind of had to learn the hard

> way that some people wanted their space. I feel very comfortable being close to another person. I feel very comfortable, I don't know… let's say touching their shoulder or touching their back. It's just something that we do a lot in my country and I didn't realize that not everybody did that until I got here. And so, with her, the body language stuff was very important for me. So, seeing that she didn't feel uncomfortable by how close I sat to her or seeing that she didn't take a step back.

When she discussed examples of close physical proximity to her therapist, Melinda described her therapist sitting close by, with no desk between them. "She would sit at the nearest couch that was close," Melinda recalled:

> Or when we first met, like, the distance between the handshaking. Even the way that she held my hand when we were shaking hands. With one hand they are holding your hand and then put the other hand on top. That made me feel very comfortable. And I think it was the familiarity of home really.

However, this preference for physical proximity was not expressed by all participants. Maria described her preference for therapy with her Latinx clinician in an office setting:

> It's like a room, like an office, like an… not, like, with a couch and stuff, but an office. Because she's also a professor. And she's just very well put together. She's always, like, dressed to the nines, like, professionally, she just has her shit together.

While Melinda wanted the familiarity of home by being physically close to her therapist, Maria appreciated the desk in the room and her therapist wearing a white coat during session. These unique perspectives about distance from therapists in session remind us of the importance of discussing and understanding the client's own personal preference towards physical proximity.

Therapist Viewed as Family

Star and Melinda both described the experience of having their therapist become more than just a therapist. Star pointed out:

> And just the fact that she would always just like, how she would react and interact with me. It's almost like she like a sister and a mom? She wasn't just like, a therapist, you know? That really helped. So much.

In response, the primary researcher reflected back Star's words, commenting "I mean, she was like family!" Star enthusiastically responded, "Yeah. She was… she is my family! And the fact that she made herself that way progressively… that really helped." Melinda described a similar desire for family connectedness and finding a familial relationship with her therapist. She stated:

> This was a woman, so being away from my own family, I almost saw her as, like, a parent figure at the time. I think at that time, I was trying to adapt to this country so hard that trying to find… and I lived in an area that had a lot of White people. I went to a high school that had a lot of White people. And so, being in an area where I didn't see many people that looked like me, other than my aunt and uncle who I lived with, of course… I think I was really wanting that connection with people like me. So, being able to see a therapist that looked like me and sounded like me was very powerful for me at that time. Even if we didn't really work on some of the eating disorder stuff. It was still pretty… it was a really powerful connection to have at the time.

By working with a Latinx therapist, Melinda experienced a powerful connection of her therapist feeling similar to a parent figure, providing her the feeling of familiarity in an unfamiliar place.

Therapist Respected by Family

Maria noted the importance of her Latinx therapist being respected by her family. As she talked about her mother's perceptions of her therapist, she stated:

> And she credits a lot to my therapist. And so, as long as I say, 'I'm seeing Dr. B,' and 'Yeah, Dr. B thinks I'm doing okay,' my mom knows not to ask questions. And so, she stays off my back… I'm okay with it because it makes this process mine. Like, my mom doesn't ask what conversations I have. She hasn't, to this day she hasn't met Dr. B… But my mom has come to respect that relationship that I have with Dr. B and she knows not to get involved. Because she's like, 'If Dr. B is helping my daughter, and she's helped her get to where she's at,' I think in my mom's eyes, she's like a savior.

By working with a therapist who identifies at Latinx, Maria noted being able to make her recovery process her own, recognizing that her mom was able to trust her treatment because of the respect she had for her therapist.

Therapist Demonstration of Strength as Empowering

Star and Melinda both described their Latinx therapists' demonstration of personal strength as inspirational, empowering, and helpful in lessening the stigma surrounding mental health concerns. As Star spoke about her therapist, she stated, "She was such like, a strong *mujer* and I was just like, 'Look, I want to be like her!' Like, I want to fight for my life right now…so at one point, I can be her." Star was not only impressed by her therapist's strength, but she found her therapist to be a model of Latinx empowerment that she could aspire towards. When discussing the stigma around mental health disorders in her country of origin, Melinda commented on the stigma being reduced by working with a Latinx therapist. "Here are some other Latinas who are doing this work," she recalled thinking. "Maybe it's not such a bad thing."

By working with a Latinx therapist, these two participants experienced, respectively, a model of strength and empowerment, and a model of acceptance for mental health concerns.

Discrimination Discussed in Therapy

When asked if discussions about discrimination were included in therapy with Melinda's therapist who identified as Latinx, Melinda enthusiastically responded, "Oh gosh, yeah!" She explained:

> With her, I felt very comfortable talking about that. I would tell her about my experiences. And I think that that was part of the rapport building, right? Because that happened within the first couple of sessions. Her asking me what my experience had been so far here… Like, when I saw that therapist at that time I had already had a bad experience with my guidance counselor in high school and I had also had a bad experience with the financial aid lady. I felt very comfortable bring that up with her, like, almost, like, 'Oh, she's going to understand this.' She's probably… that just was my assumption. Obviously, she could have not gone through any of that stuff but feeling very comfortable bringing it up because I was, like, 'Oh, she probably gets it.' Like, 'She's probably gone through some of this stuff.' So, feeling very comfortable. I never thought once about bringing that up with the other counselor.

Melinda described feeling comfortable to discuss her experiences of discrimination with her Latinx clinician, believing that her therapist would understand and perhaps had had similar experiences. The primary researcher followed up by asking how her clinician reacted when she shared discriminatory experiences. Melinda commented:

> She was very validating. I remember her, like, seeing her facial expression but also just being very vocal about, like, 'You shouldn't have experienced that. That shouldn't have been your first experience here in the U.S.' So, it was just very validating.

Not only did Melinda feel comfortable to bring up discriminatory acts with this therapist, because of her similar identities, but she felt validated by her therapist's culturally competent responses and the way she emphasized that those experiences should not have happened to her.

Therapist's Ability to Relate

The last component of culturally competent treatment provided by a Latinx therapist involves the therapist's ability to relate. All three participants who worked with a Latinx therapist commented on the feeling of relief that they experienced in not having to explain their culture to their Latinx therapist. As Star mentioned, "She would use terms, like, we got to be *chingona* [a strong woman] and we got to go out there and represent! I don't think anyone else would have said that stuff." By utilizing empowering terminology, relevant to Star, her therapist was able to express her understanding of Star's culture.

Melinda echoed the importance of having stories about her country understood and not having to explain her culture. She recalled a conversation with her therapist around beauty expectations in Colombia:

> In the eating disorders and culture, it was really nice for this person to understand where our expectations as Latinos or Latinas comes from. So, like, being able to understand that beauty pageants, like, in Colombia it's Miss Colombia or Miss Universe, it's a very big deal in our culture. So, comparing ourselves to that. To seeing, I don't know if they do that here in the U.S. but in Colombia, every time there was a pageant going on, they would always, it was the name of the lady and then her measurements, like, 90, 60, 90 or

> something like that… And her height and that was her descriptor. That was it. And so, her understanding how… how influenced we are by this, I'm going to say Miss Colombia. But I know in other Latino countries too. And so, we compare ourselves so much to that. And she had a better understanding of that. Like, I remember her, like, giving me more examples and me agreeing, like, 'Yeah, she does really get it. She does understand where this is coming from.'

Later in the interview, Melinda described another expression of understanding from her therapist when her therapist shared examples of her own experience:

> Telling her the stuff that my aunts and my mom had done over time with myths and stuff like that that they believed in Colombia would help them lose weight. And her being able to also share some examples of what, in her own country people did and it was really being able to relate. I think it goes back to the other, like, hearing and seeing that she truly gets it.

Maria described a similar feeling of knowing that her therapist understood because of similar experiences:

> With her it's been a lot easier because I don't have to explain the cultural nuances to her, I really don't. Like, she just gets it, she just understands it, so it's easy. And I don't have to explain what it was like to grow up in [my hometown]. She gets it. She grew up here.

Believing the therapist truly understood what it was like to be Latinx in the United States, participant felt their therapists would be able to relate to and understand their cultural experiences.

Intersecting Identities

Several participants, while not having the opportunity to work with a Latinx clinician, described experiences of working with and being supported by therapists and staff with marginalized identities. Working with these individuals, clients described feeling validated when discussing their cultures and described their perception that others with marginalized identities would understand the experience of being "othered" in U.S. society.

Validating Client's Concerns

Allie described her experience of being validated by her group therapist, who identified as transgender. Describing her therapist as "wonderful," Allie noted this therapist consistently validated her emotions. When Allie and the primary researcher discussed bringing up experiences of discrimination in group therapy, Allie recalled this therapist's genuine response:

> He didn't say anything, really, other than just, like, 'Tell me more about it.' 'What are you feeling?' 'What's going on?' 'Can we help you explore that in some way?'

While other members of the therapy group ignored or dismissed Allie's reaction to police shootings of Black men, Allie's therapist validated her through gently opening the door to exploring those feelings.

Ani and Maria both described being able to work with staff who were people of color at their respective treatment facilities. Ani recalled, "I felt like I could just talk about my problems and talk about my worries regarding my family and my friends and I didn't have to kind of explain the basic layers of it, you know? Like, I could just kind of talk about my problems and I didn't have to teach and explain." While all of the therapists were White, Ani described appreciating the opportunity to be around two staff members of color:

> They couldn't counsel you or give you advice or anything. But, you know, I was still kind of able to talk about my problems and I felt like I was maybe understood a little bit better because the other thing is that a lot of the staff members there, a lot of the staff members in partial also had had a history with eating disorders. You know, not all of them, but a lot of them did. And so that was really cool because, yeah, like, the two women of color who worked there, one of them was also Queer. And so, I felt like, I felt like it was a lot easier to connect because, like, we were the same! (Laughs) And so, you know, even if, even if I couldn't, like, have therapy, we were still able to talk and, like, feel validated and talk to each other on a day-to-day basis and if my counselor was not on the same page as me, I could still talk to them about it and I would be understood.

While acknowledging that working with a therapist of color would have been preferable, Ani noted that it was "great" to experience "deeper understanding" by the staff members in their partial hospitalization.

Maria also described feeling understood and listened to by the nurses of color in her treatment center. She recalled:

> My nurses were phenomenal people. Amazing. I loved them to pieces. They would listen to my mother when she would call, they, like, they, one Hispanic woman, God bless her, her and this other woman, she was, like a Filipino, and another woman that was Black, mind you, all of my little minority nurses… One of them, I had told her that I was going to be there for Christmas! I mean, I was at inpatient for Christmas! It sucks! So, she arranged for a priest to come and read gospel and, like, give the eucharist for me and to another patient who was also Catholic. And that was just so huge… That was so meaningful and so touching that she understood that that was, like, a really big deal.

By having a basic layer of understanding regarding the participants' experiences, clinicians and staff members of color were able to provide needed validation during an isolating experience.

Understanding Experience of Being Marginalized

Furthermore, Allie noted the importance of working with a therapist who understood the experience of being marginalized. As stated previously, Allie had the opportunity to work with a transgender group therapist who was masculine-identifying. She noted, "For me it felt like… they also knew what it felt like." While still White, Allie felt this therapist understood something about the experience of being "different." She noted, "I do think that there was also just the symbol of him being different that let me know that, like, he didn't… you know? He knew what it was like to be invalidated in a lot of ways."

Clients with Intersecting Identities

Ani, Allie, and Maria all noted the helpfulness of being in therapy with other clients of color. When Ani recalled their experience of being in group therapy with individuals from different backgrounds, they recalled, "I felt like we were kind of able to have an understanding there." Maria noted being the only Latinx client in treatment but remembered that one of her roommates was Indian. Allie recalled a setting in which she had marginalized members of her therapy group. She stated:

> And because it was free, there were a lot more people who, not necessarily looked like me but a lot of people who I could tell had also felt the effects of not fitting in in many treatment situations. So, there were a high number of LGBT community members, a couple of other people of color, which was the first time I'd ever seen that, a lot more masculine identifying people. And I felt a little bit better in that situation.

While none of the participants ever noted being in a treatment center or therapy group with someone who identified as Latinx, each described feeling more understood by working with other clients with intersecting identities. These accounts depict the experience of feeling less isolated in treatment by being with other clients who also did not seamlessly fit into the traditional treatment setting.

Culturally Competent Treatment

The next component of culturally competence focuses on three overall themes of meaning: financial access to treatment, awareness of Latinx culture, and an open and transparent approach to therapy.

Financial Access to Treatment

Two participants commented on their ability to access care because of financial stability. For instance, Maria described being fortunate enough to have understanding employers and "kick ass" insurance. Star, on the other, stated that she could not afford treatment, but, fortunately, was provided treatment on a scholarship. She added, "They were so helpful. They even provided me with housing close by." By providing a scholarship for her treatment, as well as housing, Star was able to access the treatment she needed for Anorexia.

Awareness of Latinx Culture

The next section describes a necessary component of culturally competent treatment: awareness of Latinx culture. Therapist openness to race and ethnicity, awareness of Latinx cultural values, and having an open and transparent approach will all be explored here.

Therapist Openness to Race and Ethnicity

Margarita, Ani, and Maria all discussed their therapists' openness to race and ethnicity as a demonstration of cultural competence. For instance, Maria mentioned her therapist asking

questions about her background, including the experiences she had growing up in her Latinx household. Ani also noted their therapist trying to understand their culture, remembering that this therapist researched and gave them a book about eating disorders written by a woman of color. Ani reflected that this effort was “really cool,” because “she went out of her way to do that.” They added, “It just felt like she put in more of an effort than just trying to give solutions that weren’t helpful.” These therapists’ attentiveness to cultural considerations, even minimally, demonstrated to the participants that they were open to learning more and discussing how culture played a role in their eating disorders.

Margarita, on the other hand, described her therapist’s openness to race and ethnicity going further than questions about her cultural experiences. Firstly, Margarita described feeling empowered by her therapist to create a framework for her cultural identity. For instance, Margarita’s therapist noted that Margarita’s experiences reminded her of what biracial kids go through. When the primary researcher asked how that resonated with her, Margarita noted that this framework made sense to her. As the interviewer and Margarita discussed why this made sense, she stated:

> I think, you know, not really fitting into one box or the other. Like, you know, like biracial kids are not White, they’re not fully White, they’re not fully Black, you know? Usually when they think about biracial, that’s what they mean. So, just kind being in this in-between… Yeah, I think the only other time that anyone had talked about race to me, like, was when I was in the first grade.

Margarita elaborated that her therapist was one of the first people to mention race, noting that “growing up in a really White area… that wasn’t on anyone’s radar.” She further explained that

there was no Latinx community either in her area. As she reflected on these conversations with her therapist, she recalled:

> I remember one time she asked me to bring pictures. She was, like, 'Just bring pictures of your life, your friends, like, stuff to give me more of an image of what your life is like.' And I brought a picture that I have, like, an old picture from elementary school when I was in Girl Scouts. And everyone in the picture was, like, blonde and White and they were all, like, huddled together in this big group hug and then I'm, like, this sad little brown girl in the corner of the picture (Laughs). And I showed that to her and she, like, pointed that out to me. Like, it hadn't even crossed, like, it hadn't even crossed my mind to think about it in terms of race because that environment was constantly telling me, like, 'Oh, we don't see color. We don't see color.'

Margarita remembered appreciating her therapist's approach to these discussions, noting the contrast between this therapist's openness to race and ethnicity versus other therapists making assumptions based on her culture. She stated:

> I think she, you know, if I think back to her style of therapy, I think she would, like, reflect certain things to me and it would make me think about them, but she didn't, you know, connect the dots or give me theories of, like, 'Is this your culture?' Or 'Maybe your culture…' Like, she didn't really push, like, any theories on me? It was more of just, like, 'So, have you thought about that?'

Margarita described not only appreciating her therapist's open and curious approach to race and ethnicity, but the fact that she was seen holistically. She recalled being viewed as an individual in treatment, with her race and ethnicity as a part of that, while also including all other aspects of who she was.

Reconnecting with Cultural Values

Participants noted a significant component of culturally competent therapy being the inclusion of Latinx cultural values. Three values participants discussed being incorporated into therapy included religion, food, and family.

Religious Beliefs

Maria discussed the importance to her of including religious beliefs and values in her therapeutic work. When she reflected on times in which Catholicism was included, she described how meaningful and touching these experiences were for her. She added:

> Everybody had an opportunity on Sunday, like, if you didn't go home for the weekend, because once you got to a certain level you could go home, like, on the weekends at [the center]. If you were there on a Sunday, you had an option to go to a church. And they would arrange for different types of services. It wasn't just, like, a Catholic church. We went to a Lutheran, we, I think we went to a temple once, we just went to a bunch of all different types. And that was, that was important because I grew up deeply Hispanic and, in the faith, doing that was very hopeful. And it was respectful because, like, they, the therapists, that's designed into the program for a reason. Because they understand that that's an important identity piece for people. So, I appreciated that… It was so positive for the healing because it's, like, something that you seek strength in, so I appreciate that they made such an effort to make a big deal out of it… And for me, like, in the Hispanic culture, that's how I was raised. It's always been a big part of my life.

As she described the inclusion of her religious values in treatment, she noted the hopefulness it provided from a faith perspective and the connection it offered to her Latinx culture. By including attending services as an aspect of treatment, Maria described feeling

respected and understood by her treatment providers, since they too acknowledged religion as an important piece of identity.

On the other hand, it is important to consider the client's religious preferences, not jumping to conclusions that a client who identifies as Latinx would want religion to be included in treatment. As Margarita shared, her therapist also brought up religion and having a spiritual relationship with God. "I think maybe she thought that if I connected to a church or something, that I would find community that I was missing. But I was not into that." She laughed and added, "My family is super religious but that was no, like, not really for me." Margarita's comments offer an important reminder to discuss and understand the client's personal preferences, with the client as the expert of their own experience, instead of making assumptions based on a client's cultural background.

Food

Allie and Maria both described reconnecting with cultural foods as an important part of healing from disordered eating. As Maria reflected on her time in treatment, she shared that she could now enjoy the foods that she likes. "It's like coming home" she noted, "and it's also that cultural connection."

Allie described the inclusion of reconnecting with cultural foods in treatment as a pivotal step in her healing process. She recalled her dietician encouraging her to cook Mexican foods, learning to cook some of her grandparents' recipes and not alter them. When asked what this was like for her, Allie stated:

> I cried a lot (Laughs). And I was really scared to do that. I tried it a couple of times. I would get into the kitchen and would, like, try it and then freak out and not be able to do it. But. Yeah. I think the first… I'm trying to remember the first thing that I made. I think

> it was enchiladas. I was able to make my grandmother's, like, enchiladas, make them perfect, and… I was so afraid of them, I was so afraid of them and I would not, like… I got my boyfriend at the time to eat the first bit. (Laughs). And then I remember being able to eat it and I was, it was really hard, but it was a really big step in my life… and my recovery. For sure.

Though an incredibly challenging goal for Allie, she described being encouraged to reconnect with cultural foods as a big step in both her recovery and her life.

Family Connectedness

In order to fully explore the value of family connectedness being included in treatment, participant experiences of family therapy, individual therapy and treatment center activities will each be considered. The inclusion of this value in culturally competent treatment seems especially important, given the first essence of the phenomenon, isolation from treatment providers and from Latinx culture. By valuing family connectedness in treatment, therapists can address both sides of isolation.

Family Therapy

Star, Ani, and Margarita all discussed their families' growth in awareness, knowledge and skills through their participation in family therapy. In regard to awareness, Margarita described her parents becoming more accepting of her food preferences, after discussions with her therapist. While she could not recall the specifics of the conversation between her therapist and her mother, she stated:

> Because she must have talked to my mom and, like, my mom came around to, like, making different food for me that I was more likely to eat. Like, chicken or fish. Or, like, letting me cook separate meals if she made, like, she made something for the family… I

> just remember that I was in treatment when that was happening and so, I think, I think my mom was kind of, like, accepting that she wasn't going to be able to figure this out on her own or control what I ate and it was going to be better to, like, work with me instead of, like, you know, pushing, coming down on the whole parental authority, like, 'Do what I say.'

Margarita added:

> And I think, like, before I was in treatment, people were, like, 'Oh my god, you're such a weirdo. You need to shut the fuck up and eat what we made.' And so, I did notice that shift in, like, my family. It was kind of like, 'Okay, whatever makes you happy. If it means you eat. We're going to drop this food thing.'

Margarita noticed a significant shift in understanding and awareness for her family through their involvement in family therapy, leading them to "work with" Margarita to encourage her eating, instead of maintaining their previous expectations.

When considering knowledge gained through family therapy, Ani remembered their parents coming up with questions that they had for Ani's therapist. They stated:

> Well, my therapist reached out and just kind of asked them if they had any, anything that they were confused about or that they wanted to know about or wanted clarification on or whatever. And so, my mom and my dad ended up sitting down and, like, putting together a list of questions or whatever… So, I think they just kind of had a conversation, a conversation about eating disorders and specifically, like, my issues. And you know, mind you, at this time, I'm also still learning about eating disorders, I'm also still learning about what my needs are and what my issues are and what my triggers are… Because, like I said, I didn't even really know that this was a thing for me. And so, so, that made it

> a lot easier for me too because, you know, especially when I first when into treatment, there was not much I could offer my parents, even if they did, like, kind of ask what was wrong… I didn't really know half the time. So, you know, it was really helpful for my therapist to kind of explain, I don't know, I guess how eating disorders work and whatever else they were questioning and also kind of explaining to my parents, like, what is helpful to me and what isn't. And I guess it just kind of, like, made them understand and kind of motivated them a little bit more to kind of be a little bit more tender towards me and ask me, ask me things.

Ani recalled this experience being helpful for their family, noticing that their parents were more curious, asked questions, and asked what they needed in subsequent visits. Ani noted, "There was something there that made them understand things a little bit better and made it easier for them to reach out to me." By providing the opportunity for Ani's parents to ask questions, the therapist offered tailored psychoeducation to the family, fostering needed familial connection during a confusing time.

Lastly, looking at skills gained through family therapy, Star described her mother learning not to make comments about Star's body through her involvement in family therapy. She also described her mother's openness towards demonstrating emotion and affection through this work:

> My mom never did that with me. Not like she was cold, she just… it's just not how she grew up. And then, like, sometimes it's still hard for me to be… to show vulnerability because you're not supposed to cry, be vulnerable… But then after therapy and everything and discovering that that's okay and, like, we're all human beings, like, you know? That helped me so much because sometimes I'll cry, and I'll call my mom and I'll

cry and she'll be like, 'Why are you crying?' And I'll explain to her, I'm just an emotional human, like we're all only human and we've got to be nice to ourselves. And then she'll be like, 'You're right. You're only human.'

Star described her mother now telling Star that she loves her. "She would never say that to me before," Star added. As she reflected on what her mother learned through therapy, Star added, "And I feel like I've helped her, you know?" By engaging in culturally competent family therapy, this therapist was not only able to help Star in her healing by incorporating the value of family connectedness into treatment, but she also empowered Star's mother to open herself up to emotional understanding in a profound and impactful way.

Individual Therapy

Participants also described experiences in individual therapy in which they were able to connect with their value of family. This was possible only given an understanding by clinicians of the lack of existence of Anorexia Nervosa in Latinx culture. As Star noted her therapist stating, "This stuff doesn't happen." By recognizing that Anorexia is not discussed in Latinx families, some therapists understood the importance of having discussions in therapy around explaining Anorexia to clients' families.

Star, Ani, and Maria all described talking with the therapists about how to explain eating disorders to their family. Star recalled these conversations as extremely important, given her family did not understand what was happening for her. "I don't know how to tell my family," she remembered saying to her therapist, "Or explain to people what I'm going through." Indeed, Ani described not feeling prepared to explain their eating disorder to their family, stating that they were still learning about the eating disorder themselves, determining what their needs, issues, and triggers were. Lastly, Maria remembered prepping in individual therapy for her family

session, preparing for the conversation and mapping out what she wanted to say. It is important to note the difference between conversations in individual therapy about how to explain disordered eating to family versus conversations in individual therapy *about* family dynamics, *without* incorporating family into therapy. By discussing and preparing in individual therapy for conversations with family, these therapists highlighted the value of family connectedness.

Treatment Center Activities

The last component of the value of connectedness being included in treatment involves treatment facilities incorporating activities for human connection. With several participants mentioning the physical distance that they experienced with their family while in treatment, activities which value human connection may be important in the isolating experience of Anorexia treatment. For instance, Maria described, during her time in treatment, volunteering at a local senior community center. She stated:

> I met this old lady and befriended her and when we would go visit, like, during our volunteer times, she was just my little partner. So that was touching. To develop a relationship with someone who would just, she came up to me and was like, 'What's going on, girl? You just, you're better than this. We need to lift you up out of this because you've got a good soul.' We continued to keep in touch afterwards, up until her death because she passed, she sadly passed a few years later… but she and I remained close. So that was another big piece that I appreciated, like, being incorporated into the treatment plan was volunteering… That was, for like connection, for human connection.

Maria recalled that the human connection she experienced at this point in her treatment made it easier to heal. "Because it was a safe space," she said, "And that's what we needed." Maria described this experience as a way to relearn how to reconnect with the real world, in the context

of a safety net. While this example does not seamlessly fit under the category of family connectedness, it provides a helpful reminder of the importance of human connection in treatment, particularly in the context of this isolating experience.

Open and Transparent Approach

The last theme of meaning pertaining to culturally competent treatment includes the therapist's open and transparent approach to treatment. Several participants pointed to the open and transparent approach that they experienced with their therapists as conducive to growth. The therapist demonstrating affect and self-disclosing appropriately were two important areas in demonstrating cultural competence.

Therapist Demonstrating Affect

Star, Melinda, Margarita and Allie all described their therapists demonstrating affect and mirroring their own emotional experience as important signs of understanding in their therapeutic work. Star, for example, explained the emotional connection she experienced with her therapist. She recalled:

> When I would cry, she would cry, and when I would be happy, she would be ecstatic. Like, my emotions were really intense, hers were just, like, triple. And I feel like we connected in that way.

As we discussed this genuine emotional reaction from her therapy, Star recalled a poignant time in her work in treatment:

> I remember there was this one time and I love this time. I started gaining weight, right? And it was the scariest thing for me… because my eating disorder, we call him 'Ed.' He's a man and his name is Ed. And we all hated him. And he would be like, 'No! You're getting fat and no one's going to like you!' You know, saying a bunch of stuff in your

> head. And so, that was going on and I was gaining weight and I was feeling it, I was just really sad and mad and then Ed was just like, 'Do this!' And there was a point where it just flipped. Like, it just flipped, and I was really happy to gain weight. I was like, 'I have curves now! I feel so good!' You know? Like, 'I can exercise now!' Because, you know, for a while I couldn't because I just would feel bad. And it's like, 'It feels so good!' Because I used to be in track and field and I was just like, 'Oh my gosh, this is amazing!' And I just, like, loved my body. And so, I went to it. And I started reading articles about loving your body and all that stuff and seeing a bunch of role models, Latina role models… And so, I went to my therapist and we had a session and she asked me how I was doing, and I was just like, 'I'm so happy. I can't stop talking about how much I love my body.' And just like a complete… it was so different from how I had talked with her before. And she was just, like, crying, she started crying, and she was like, 'I can't believe that this is happening!' I mean, she was just like, 'I can, but I can't…' We were celebrating. I clicked with her even more because then I feel like I woke up. Like, I could talk to her other issues like, you know, life, herself, like, what she was doing. It was just like, I was finally becoming myself.

This moment in therapy captures the connection that Star shared with her therapist and illustrates her therapist's willingness to demonstrate affect as key to this emotional bond that they shared.

Melinda also noted her therapist's genuine reaction stating, "There was something about her genuine reactions that truly gave me the understanding that she understood. And that I think really helped the relationship." She recalled this being evident not only with her words, but with her nonverbals as well:

> I remember her, like, very shocking, like shocked facial expressions and everything. Very expressive. And I liked that. I really did. Because I think that that's another level of being personal. Like, being very genuine too.

Allie and Margarita both commented on the personal connection that their therapists established with their clients. This was evident for Allie when she noticed her group therapist was intentional about knowing the names of all of the members of the group. She also recalled her therapist checking in with her at the end of a challenging session to see if he could provide her with any support. Margarita also recalled the inclusion of her art in therapy as a testament to the personal approach of her therapist. She stated:

> I would bring him my sketchbook and he would show me his pictures. It was not like an in-and-out, like, 'I'm going to check your weight,' and, you know? 'See how your body is doing.' It was more of, like, like, this adult who really cared about me. I think, you know, a big part of this was, I grew up feeling so invisible. Like, to feel seen by anyone. And I think what was helpful in treatment was feeling seen for the first time.

Margarita's experience of feeling seen in therapy demonstrates the importance of a personal and intentional approach from the therapist and further emphasizes the need for genuine and emotional connection in an experience defined by isolation.

Appropriate Self-Disclosure

The final area of culturally competent treatment involves the use of appropriate self-disclosure as a therapeutic tool in treatment. Star, Melinda, Maria and Margarita all described instances in treatment in which their therapists shared pieces of themselves in a constructive and client-focused way. Star remembered her Latinx therapist drawing parallels between Star's experience and her own, sharing that her own family did not always understand her concerns

either. Melinda's therapist shared examples of diet myths and techniques in her culture, demonstrating her ability to relate to Melinda's experiences. Melinda recalled feeling that these disclosures demonstrated that her therapist truly understood. "Because one way or another," Melinda added, "it sounded like she had also experienced it."

Maria and Margarita both emphasized the need for appropriate self-disclosure in therapy. Indeed, Maria described feeling concerned when therapists over-shared: "I've had therapists who sometimes I felt like I was their therapist. Where, like, you cross that line of, like, patient and doctor where the patient now is, like, listening to you bitch and moan and that's not okay." She pointed out that in her current therapeutic relationship, her therapist only shares information that is beneficial to her progress. Acknowledging that she knows some of the basic information about her therapist, Maria described her appreciation that when she is in session, it is about her. Specifically, Maria noticed that her therapist will bring up her own family but only if it's in relation to something Maria has shared. Margarita also commented on working with a therapist that predominantly spoke about herself. "It wasn't really therapy," Margarita added. Self-disclosure of the therapist, particularly when drawing parallels between the client's experience and their own, appeared to be a helpful tool in therapy for participants. However, Maria and Margarita's comments emphasize that therapist sharing should solely be for the benefit of client progress.

All in all, participants described appreciating open and transparent approaches to therapy, as well as awareness of Latinx culture. Participants valued when their therapists had also encountered experiences of feeling marginalized or othered in U.S. society. This ability to relate was especially powerful when participants worked with Latinx clinicians, although the

opportunity of working with a Latinx clinician who specialized in eating disorder treatment was reported to be rare.

CHAPTER V

DISCUSSSION

While the use of terms such as "social justice" and "cultural competence" have become commonplace in the field of psychology, their applicability to Anorexia treatment has not been explored. A belief of "immunity" for Latinx clients to Anorexia Nervosa has created misconceptions around who can be diagnosed with Anorexia and who cannot. While Latinx communities represent the fastest growing demographic group in the U.S, Latinx individuals are largely underrepresented in eating disorder literature. Indeed, to the understanding of the primary researcher, there has not been a single research article published looking specifically at Anorexia Nervosa for individuals who identify as Latinx.

Therefore, interviewing individuals who identified as Latinx and had been in treatment for Anorexia appeared necessary to develop preliminary understandings around the experience of treatment, as well as if participants' cultural backgrounds and values were included in therapy. The research questions were: 1) What are the cultural experiences of Latinx clients in eating disorder treatment for Anorexia Nervosa? 2) What perceptions do Latinx clients have regarding the cultural competence of therapists for the treatment of Anorexia Nervosa? 3) In what ways, if any, do Latinx clients believe cultural factors played a role in engaging in treatment for Anorexia Nervosa?

Summary of Results

Using Dahlberg's (2008) Reflective Lifeworld Research approach, two major essences of the phenomenon of Anorexia treatment for Latinx clients emerged. While two essence of the

phenomenon were found, the stories of each participant were unique and specific to their own lived experiences. Although this research attempts to conceptualize the experiences of seven participants, it does not aim to make definite what is indefinite, or claim to have explored all meanings, themes, and essences of the phenomenon (Dahlberg & Dahlberg, 2003).

Essence One: Isolation

An overarching essence of the phenomenon can be described as "Isolation." Participants described their experiences of not meeting expectations and not fitting in throughout their time in treatment for Anorexia, both with providers and within their culture.

Disconnection from Mental Health Providers

Participants described the experience of feeling disconnected from White mental health providers for Anorexia Treatment. Power and privilege in a White dominated field appeared to contribute to these experiences of isolation. Five themes of meaning arose in participant interviews: barriers to treatment, belief of immunity from eating disorders, appropriate distrust, emphasis on individual therapy, and lack of cultural awareness.

From the moment participants sought treatment, or were informed that treatment was imminent for survival, participants described being thrust into a world that they had little knowledge of. They were always the only Latinx clients in treatment. From the beginning, participants felt that they were not meeting the expectations for treatment and, therefore, did not fit in.

Before accessing treatment, participants described the experience of isolation in trying to get in the door at treatment facilities, due to significant barriers, including finances and distance to treatment providers. Even if they were able to access treatment, participants often experienced misdiagnosis or delayed diagnosis. Several participants described their treatment providers not

seeing them and their symptoms, believing that Latinx clients are immune from Anorexia Nervosa. Based on an overemphasis on White norms, participants noticed their providers' failure to identify Anorexia Nervosa because they did not identify as White. Almost every participant noted a significant delay in diagnosis, the longest being almost 15 years of battling the disorder. These examples illustrate providers' belief in immunity for Latinx clients and that these misconceptions prevent Latinx clients from accessing treatment; it also reemphasizes the power and privilege of the White dominated field of psychology, which dictates what Anorexia Nervosa should look like and how it is defined.

If participants were able to make it into a treatment facility and receive a diagnosis, they described being appropriately distrusting of providers, based on experiences of discrimination outside of therapy and resistance from family members. In treatment with White providers, participants described a lack of cultural awareness such as not bringing in cultural values and experiencing discrimination in treatment. Participants described their cultural experiences and values being dismissed and invalidated in therapeutic settings.

Importantly, several participants noted their value of family not being incorporated into treatment, as evidenced by a lack of or culturally incompetent family therapy. These examples not only represented an emphasis on individual therapy, promoted by a White dominated field's value of individualistic culture, but also overlooked the value of family connectedness. Participants noted being asked by providers to have conversations with their family members outside of therapy without considering how culture could impact these conversations.

In the entire process of receiving treatment, from finding treatment providers, receiving a diagnosis, to participating in individual and group therapy services, participants described experiences of isolation. Because they did not identify as White and wealthy, participants did not

meet the expectations nor fit in in traditional treatment settings for Anorexia. This experience of isolation is even more paramount when considering the common factors approach to psychotherapy, which hails therapeutic alliance as one of the most important elements for therapy to be effective (Lambert, 1992).

Disconnection from Latinx Culture

Participants also described a disconnection from their Latinx cultures. Three major components of isolation in regard to culture included disconnection from identities, cultural values, and the pervasive stigma around mental health concerns in their communities. Participants noted not feeling connected to their cultures of origin. Several described not knowing who they were at the time they were in treatment and that they had lost all of their identities. Indeed, during their times in treatment, participants described feeling disconnected from Latinx cultural values that brought feelings of connection to their families and communities. Food and family were inextricably linked in this domain; participants described the expectations of receiving food in the family, recognizing that food was given as a sign of love, but also described not being able to explain to their families the complicated relationship they were experiencing with food. Since eating disorders "did not exist" or were not be talked about in their communities, families did not understand the emotional and psychological components of Anorexia, only viewing the disorder as food refusal.

However, as seen in the previous section, the opportunities for culturally competent family therapy were few. If participants were offered family therapy, external barriers, such as family responsibilities, immigration status, and distance, as well as internal barriers, such as fear, presented significant impediments to attending treatment. Therapists may not have considered the privileges that a client and their family have for being able to attend family therapy.

Each participant described experiences of isolation when discussing being in Anorexia treatment. While, again, no research has explored the experiences of Anorexia for Latinx clients, research suggests social isolation to be a common response in adolescent girls with Anorexia (Damiano, Reece, Reid, Atkins, & Patton, 2015). Since isolation is often a way for a client with Anorexia to both cope with emotional distress and protect one's eating disorder, the experience of isolation for these participants is especially dangerous. An emphasis in treatment on the therapeutic alliance, family therapy, and group therapy is ineffective if culturally competent treatment, which considers the values and challenges unique to each family, is not provided by eating disorder specialists.

Costs of Culturally Incompetent Treatment

Early termination, assimilation to White culture, and undertaking the recovery process independently were significant costs for participants from receiving culturally incompetent treatment. Five of the seven participants recalled ending treatment with their therapists early. Moreover, several participants discussed feeling that they were more accepted and heard in therapy if they pretended to be White. In this White dominated field, assimilation to White culture was an adaptive response for survival when their cultural experiences were ignored dismissed, and invalidated. Lastly, participants also described believing that their treatment would have taken less time, or that they would not have had to undertake the recovery process independently if they had received culturally competent treatment. These costs not only warn against culturally incompetent treatment, but they also remind us of the isolation involved in each of these costs. The isolation of having to leave treatment early, the isolation of having to separate from one's cultural identities to be listened to, and the isolation of having to undertake the recovery process alone.

Essence Two: Cultural Competence

The second essence of the phenomenon was cultural competence. Disappointingly, this essence of the phenomenon was significantly less developed than the essence of isolation, since the majority of participants had not experienced culturally competent therapy. However, this contrast emphasizes the importance of exploring this area through research, building off of this foundation in order to provide culturally competent treatment for Latinx clients in Anorexia treatment.

Firstly, participants found that their therapists' intersecting identities played a significant role in the provision of culturally competent treatment. When working with Latinx therapists, participants described the ways in which their therapists' identities, actions and words demonstrated their value and understanding of Latinx culture. Importantly, participants did not feel that they had to explain the nuances of their culture to Latinx therapists and felt that their cultural values were seamlessly incorporated into treatment. Moreover, participants were able to discuss experiences of discrimination and oppression in the room and consider connections between these experiences and their experiences of disordered eating. Participants also discussed working with and being support by therapists and staff in treatment settings with marginalized identities. Working with these individuals, participants described feeling validated when discussing their culture and noted a common understanding of the experience of being "othered" in U.S. society.

Other components of culturally competent therapy included providing access to treatment, awareness of Latinx culture, and an open and transparent approach to therapy. Importantly, given the experience of isolation and disconnection from values explored above, participants described positive experiences when they were supported and empowered in

treatment to reconnect with cultural values. By including Latinx cultural values, such as religion, food, and family, participants began to feel reconnected to a piece of themselves and who they are. Importantly, this area also offered an important reminder regarding the client's unique and personal preferences. While some participants described family and religion as pivotal areas to reconnect with in their journey towards recovery, others felt that this assumption about their values, based solely on their cultural background, did not capture who they were as an individual. This aspect of the phenomenon reemphasized the importance of discussing and understanding clients' personal preferences, instead of making assumptions based on a client's culture.

Implications

After participants shared their experiences of treatment, they were asked what culturally competent eating disorder treatment would look like. By incorporating participants' responses, and moving beyond the phenomenon, this section addresses five major areas for improvement. These areas include: understanding Latinx cultural values, family generational experiences, culturally competent family therapy, the inclusion of Latinx eating disorder specialists, and advocacy and awareness. While these implications are not all-inclusive, they are imperative areas for improving cultural competence when treating Latinx clients with Anorexia. These recommendations also come directly from participants, which increases their value and significance.

Cultural Competence

Broadly, participants emphasized the importance of talking about race, ethnicity and culture in treatment. Angela noted the importance of therapist humility when having these

conversations, being mindful and aware that all Latinx clients' experiences are not the same. When describing the importance of bringing culture into treatment, she added:

> But you can't do so from a place of authority or a place of assuming you know all about them because you've taken one class or have background knowledge on this and sometimes too even, like, working with other people within the Latino community? Like, even though I do identify as Latino, my experience isn't the same as someone of a different nationality background and so I also try to remain humble, like, not all Latino experiences are the same. Not all eating disorder experiences are the same. So, I guess, yes, we need to have more trainings and we need to talk about culture more and bring it into discussion, like, as an important piece, but just having humility around that and knowing that you're not going to know that person's experience until you just sit and listen and ask more.

Angela's words paint a picture of cultural humility which has been explored by Foronda, Baptist, Reinholdt, and Ousman (2016) who describe cultural humility as "a process of openness, self-awareness, being egoless, and incorporating critique after willingly interacting with diverse individuals" (p. 213). While valuing cultural competence, cultural humility offers a unique facet to this phenomenon, focusing on the therapists *being* with their clients and valuing their intersecting identities. According to Angela, this interaction involves not assuming you know the client's experiences or generalizing based on research and study. Instead, humility involves sitting down and asking more.

The importance of a therapist's willingness to listen and be supportive was also described by Allie. She pointed out that this is particularly important for White therapists given the distrust among people of color towards White people. "The world is really scary right now… and for

Latinx people and Latinas, we're really experiencing a pretty traumatic time," she added. She noted the importance of listening and not taking offense to what the other person shares.

For White therapists working with clients of color, it is imperative for therapists to acknowledge the inherent privilege they carry in the therapy room. Clients may carry, understandably, feelings of cultural distrust and negative feelings towards White people that may impact the therapeutic alliance (2003). Moreover, White therapists who critically deconstruct the thin ideal with their clients who are women of color may be viewed as hypocritical and privileged in their ability to dismantle a culture that readily accepts them (2003). These patterns of distrust may continue, thwarting the therapeutic alliance, if not discussed openly and honestly with clients. Gilbert (2003) contended that therapists may improve treatment outcomes by pursuing direct and honest discussions surrounding race and culture with clients.

Both Angela and Allie noted the importance of self-reflection and self-awareness around bias and privilege. They encouraged clinicians to be willing to explore when privilege and bias are preventing them from understanding, listening, and validating clients' experiences. Only when clinicians are willing to admit that they do not know everything and question how their personal biases impact their therapeutic work can they truly be able to validate and hear what their client is experiencing. Allie recalled her story being consistently marked by clinicians as "wrong" or "not real." She encouraged providers to hear and validate what people are going through, helping them to continue to talk and open up about their experiences. "That's the only real way to get to any healing."

As Derald Sue et al. (2007) suggested, a culturally competent therapist must, gain "(a) awareness of oneself as a racial/cultural being and of the biases, stereotypes, and assumptions that influence worldviews and (b) awareness of the worldviews of culturally diverse clients" (p.

271). Through this process of reflection, acknowledgement and awareness begins prior to clinical work and continues through the therapeutic process. As clinicians continue to encounter biases, stereotypes and assumptions in clinical work, it is imperative for them to pursue self-assessment and consultation surrounding these beliefs and feelings (Palmer, 2007). Moreover, the onus is on the clinician to seek out knowledge of and gain awareness of the client's culture, not solely relying on the client to teach the clinician about his or her cultural experiences (2007).

Understanding Latinx Cultural Values

Ani described the importance of recognizing the unique intersecting identities and background of each client battling with Anorexia. "One single thing doesn't work for everybody and their family," they added. An individual with an eating disorder must be understood in the context of family, community, and the overarching social structure if clinicians are to engage in culturally competent treatment planning (Palmer, 2007). Importantly, Angela noted the significance of discussing the cultural value of food in treatment, stating that it would be helpful if the therapist discussed how the client's culture handles food and what the relationship is between food, family, and holidays. Several participants noted that food held a significant role in the family; they spoke to the expectations around food in the family, commenting that food is viewed as a sign of care by elders and it is disrespectful to refuse food. By overlooking the value, expectations, and respect associated with food in the family, clinicians may provide recommendations that are neither appropriate nor helpful for the client.

All in all, according to Latino Centered Counseling Competencies, developed by Gallardo-Cooper et al. (2006), clinicians must attend to several key considerations when working with Latinx clients: family and family members, identity, acculturation, language, family factors, stressors, and protective factors. Language preference must be considered for therapy and openly

discussed with clients. In assessing *la familia*, clinicians may need to ask questions regarding relevant family members and their potential involvement in the treatment process. Family values such as *familismo*, *respeto*, and *cariño*, may be explored as a component of a strengths-based approach to therapy. Clinicians must work to examine the acculturation process, understanding acculturation as complex, multidimensional and dynamic. Indeed, it is important that acculturation be discussed collaboratively and throughout sessions, not limiting its mention to the initial intake session (Arredondo et al., 2014). Transparent conversations regarding prejudice, discrimination and racism must be openly considered and discussed throughout therapeutic work. Lastly, both in and outside of session, clinicians must practice self-evaluation, expand knowledge on Latinx values, and consider culturally competent Latinx-centered clinical skills. As Arredondo et al. (2014) state, “An interpersonal, culturally based etiquette is recommended, as are adaptations to the family’s preferred communication and problem-solving style” (p. 170).

Family Generational Experiences

Several participants pointed out the importance of understanding and incorporating generational experiences into the therapeutic work, understanding the role of colonialism and Latinx history. Angela, for example, noted the importance of understanding the history of her family when considering her relationship with eating and food. By only focusing on the direct experiences of herself, as the client, Angela felt that the impact of generational experiences was overlooked. She understood that her experiences with trauma, anxiety, and food were based not only in her experiences growing up, but also the experiences of her mother and grandmother. She recalled having more patience with herself after she made this connection, realizing that her own direct experiences did not explain the entire picture. “It does have to do with kind of this bigger picture of your background and where you come from,” she added.

Body positivity movements created for persons of color are beginning to address the detrimental history of body image. As Gloria Lucas, the founder of Nalgona Positivity Pride explains, "People of color received very mixed messages about their bodies. There's the message that we're inferior, that we are dirty, that we are ugly, that we're not intelligent" (Ramirez, 2016, p. 1). The history of oppression against the bodies of people of color has been passed down from generation to generation, perpetuating "the belief that White, slender bodies are desirable; and darker, curvier bodies are not" (2016, p. 1). While focusing on the direct experiences, beliefs, and behaviors of each client is important, clinicians should continue to learn and understand the ways in which generational experiences impact clients' relationships with their bodies and with food.

Moreover, a clinician's ability to gain awareness of a client's acculturation to his or her traditional culture or the dominant culture is imperative in understanding the client's beliefs surrounding body image, weight, and food (Talleyrand, 2012). Depending on the client's level of acculturation, attitudes towards physical appearance and feelings surrounding food may have been passed down from previous generations in the family and may also be impacted by the dominant culture's emphasis on physical appearance. Through therapeutic interventions, individuals with eating disorders may be able to nonjudgmentally acknowledge the potential discrepancies between the values of their culture of origin and those of the mainstream culture (Gilbert, 2003).

Family Therapy

This research also emphasized the importance of a focus on systems. While individual therapy, promoted by a White dominated field that values individualistic culture, may be helpful for some clients, family therapy may be more appropriate. As we heard from participants, clients

may be put in a challenging place if they are encouraged to make decisions about their family in individual therapy, without their therapist recognizing the value of family connectedness.

Due to the stigma around mental health concerns and the lack of understanding of eating disorders, family members may not approve of therapy or understand the meaning behind it. Some families may question why the client cannot talk to them about their concerns or may recommend relying on spiritual or religious guidance. Several participants noted needing to have the most important people in their life present during treatment for support, while simultaneously being aware of the barriers for family involvement.

Participants offered specific recommendations that would be helpful to competently include their families in treatment; overwhelmingly, participants recommended psychoeducation for their family members about eating disorders, especially Anorexia. Eating disorder specialists cannot assume that all families understand what an eating disorder is and believe that treatment is an appropriate course of action. Prior to engaging in family sessions, many participants described being prepped or coached on what they wanted to discuss with their families and how to explain their concerns. However, they did not feel that their families were adequately prepared for these interactions. Maria noted that if her therapist had a conversation with her parents, they may have been able to better understand where they were coming from. She added:

> The way that she prepared me for the conversation, I would have liked for her to have that with my parents as well. Because I think it would have helped them and it would have helped her navigate our dynamic… One, for her to, like, get better understanding of, like, stuff in the family dynamics, but also for my parents to have some of their questions answered. Because they just weren't getting the information that I think they would have liked to have gotten.

As Ani described earlier, a helpful intervention from their therapist was asking Ani's family if they had any specific questions that they wanted answered about Anorexia and its treatment. Treatment providers may consider including an opportunity for family members to ask questions so that appropriate and helpful psychoeducation may be provided. Having psychoeducation occur prior to family therapy, either digitally or in-person, may increase family understanding and openness to therapy. Moreover, clinicians may need to move beyond their traditional roles to assist clients in talking to their families. Allie described wishing she had a "cultural advocate" to explain Anorexia to her father and grandparents, and to help them understand that Anorexia does exist in Latinx communities. "It would have been really helpful to have a therapist who would say, 'No. This is something that is happening,'" Allie added. She noted that having this conversation may have facilitated a discussion that Allie was not sure how to have with her family. Connecting with family members prior to family therapy to answer any questions and hear their perspectives could be a helpful tool for clinicians to counter the experience of isolation that participants experienced.

Latinx Eating Disorder Specialists

However, the conversations recommended above are not always possible without providing bilingual therapy, translators, and materials in Spanish. Allie described the necessity of having a therapist who could speak Spanish, or even a translator, to assist her in talking to her family. She noted that being able to translate written materials and information about her disorder into Spanish would have assisted her in explaining what she was going through to her family.

Three participants specifically described the importance of having more Latinx therapists and social workers in eating disorder treatment settings. Importantly, Melinda noted having to

make a choice between a Latinx therapist, who would understand her culture and her language, or working with a therapist who would be able to help treat her eating disorder. When only 9% of those who earn their doctorates in psychology identify as Latinx, the inclusion of Latinx clinicians in the field of psychology is an important concern (U.S. Department of Education, 2012). An increase of Latinx clinicians in the field can only occur as educational systems support, both emotionally and financially, the inclusion of Latinx students in master's and doctoral programs for counseling and psychology. As Angela added, "that would overall have a greater impact on the mental health of the Latino community."

Advocacy and Awareness

Participants also emphasized the importance of advocacy and awareness around the prevalence of eating disorders in Latinx communities. Participants questioned whether they had an eating disorder because they were not aware of other Latinx individuals with them. "I haven't heard of any other Latina that has… disordered eating or an eating disorder," Melinda state. Allie noted that many Latinx individuals do not know that there is an option for help or where they can get help. She added:

> I don't think a lot of us even talk about it when it does happen. I feel like there's a lot of shame in families about something like this because food is such a huge part of our culture that it's so, completely misunderstood, it's a very misunderstood thing, and I think there's a lot of stigma around it. And I think that families don't even, you know, know that it could be a problem. Especially in some of the ways, like, for Anorexia Nervosa it's seen as such a weird thing? That was my diagnosis. It just seems like such a weird, random outlier, like, when would you, you know, have issues with food?

With Anorexia being seen as an anomaly in Latinx communities, spreading awareness within Latinx communities is imperative. This is where the role of psychologists moves past the therapy room again. As advocates, therapists recognize that lasting differences do not only occur with change in the therapy room but include systemic change in client environments and communities.

Limitations

This study was the first to provide an in-depth examination of the experiences of Anorexia Nervosa treatment with Latinx clients. Despite the strengths of the study and its design, several limitations arose pertaining to the qualitative approach and the sample of participants. Firstly, while Dahlberg's Reflective Lifeworld Research approach offers the privilege and honor for researchers of being able to enter into the participant's lifeworld, a major limitation of this approach is the lack of critical theoretical frameworks around racial and gender identities, such as Critical Race Theory and LatCrit. Due to the sparse research on this topic, a more exploratory approach was used in the current study to uncover a basic understanding of the phenomenon. However, the role that culture, race, and ethnicity play in these participants' experiences is undeniable; future research must examine this phenomenon within a cultural lens in order to focus on cultural experiences throughout the entire research process.

Secondly, interviews were collected on a phenomenon that often occurred several years prior. Some of the specifics of the phenomenon, including moments in therapy, may have been left out of the interviews because of the time elapsed. From a measurement perspective, this study did not measure Latinx identity to determine what Latinx culture meant to each participant; however, the way in which Latinx culture was or was not internalized was apparent in the interviews and captured in the themes and essences of the phenomenon. Moreover, while all of

the interviewees in this study identified as Latinx, many participants described different countries of origin. Because of the limitations of the sample, this research was not able to explore the unique experiences for participants, their families, and their communities based on their specific cultural backgrounds.

Lastly, as the primary researcher, I do not identify as Latinx. My identity as an outsider of the group may have impacted two major areas of the research process: participant recruitment and the quality of the interviews. In regard to recruitment, I had difficulty recruiting participants for the first six months of the project. My identity as a White clinician may have discouraged participants from reaching out; given the climate of our country, and the hateful rhetoric around immigrants and Latinx individuals, I completely understood their reluctance and distrust. Secondly, my identity as a White researcher may have impacted what participants were willing to share with me. Specifically, participants may not have wanted to give voice to their negative experiences with White clinicians, given the power differential in the interview of speaking with a White clinician. With this power dynamic constantly on my mind, I attempted to approach each interview with openness and transparency. Firstly, I began each interview by describing my identities, what led me to this topic, and asking the participant if they had any questions about me or my interests. Moreover, throughout the interviews, I was intentional about validating the experiences of the participants; I did not want to replicate the experiences of dismissal and invalidation that many participants reported during their time in therapy with White clinicians. To assist with this limitation, I was intentional in recruiting two research team members who both identify as Latinx and having the analysis audited by a Latinx psychologist.

Lastly, there is very little research on the effects on participants of researching eating disorders and body image. Participants with Anorexia Nervosa may find discussing their

disordered eating behavior to be distressing. Therefore, I was intentional throughout the interviews to consider the potentially distressing nature of the questions and to check in with participants about how they were doing. At the end of the interviews, I checked in with participants about how they were feeling and often discussed what they had planned for self-care that day. Additionally, the day after the interviews, I sent e-mails to participants asking if they needed any additional resources or any other support. These gestures were not from a place of wanting to check a box that I had followed up with participants; instead, these came from genuine empathy and wanting to honor each person who was willing to open themselves up in such a vulnerable and emotional way.

Recommendations for Future Research

With these unique experiences in mind, the development and manifestation of eating disorders for Latinx clients must, undoubtedly, be considered within context. By acknowledging the development of disordered eating from this lens, clinicians may begin to understand the purpose Anorexia serves the individual, utilizing this information to provide effective intervention that may vary from traditional approaches. By looking at differences in clients' clinical presentations, psychologists and researchers may gain understanding around the differences in etiological pathways of eating disorder development for women of color.

Importantly, researchers must move away from comparisons of women of color "versus" White women, looking for a "White-not-White" dichotomy (Bay-Cheng, Zucker, Stewart, & Pomerleau, 2002). Researchers must explore similarities and differences among diverse racial and ethnic groups. By looking at within-group differences in clinical presentations, researchers may be able to explore the specific within-group cultural needs in eating disorder treatment. Moreover, this in-depth approach would allow researchers to examine these differences, as well

as interactions with socioeconomic status, sexual orientation and identity, and gender identity (Capodilupo & Forsyth, 2014). In addition, focus groups could provide a unique experience for participants, giving members the opportunity to discuss their experiences. Not only would this demonstrate to participants that they are not the only Latinx person with Anorexia, but this method would be consistent with the collectivist values of Latinx culture. The experience of a focus group may also assist participants in recalling moments and memories in treatment that they may have otherwise forgotten. Moreover, a focus group of Latinx participants dedicated to the experiences of having Anorexia more broadly could be beneficial in exploring etiology and factors that contribute to seeking out treatment.

Closing Thoughts

> *I feel like, the eating disorder is kind of… a metaphor for life. My mom was making all of these comments about me becoming invisible, and its sort of like, I am invisible. You know, like, there's literally no space for me here. And my body took up less space.*

The above quote is from one of the brave participants who participated in this study, Margarita. Margarita described her experience, as a Latinx female, of not feeling seen. Margarita recounted experiences of not being seen in her community, a White-dominated area which ignored racial and cultural differences. She described not being seen by her family as she battled with Anorexia. And she recalled experiences in therapy of not being seen by her providers. This experience of isolation, not fitting into treatment, and not meeting expectations, cannot be ignored. I will not ignore this isolation and will do all in my power to help others understand these seven stories. There is not a day that goes by that I do not think about what these participants shared with me and how it has changed me as a person.

As I reflect on this experience, reading through pages of memos, I recall the self-doubt that occurred throughout the process. Sometimes interviews concluded where I noted feeling like I had to prove to my participants that I was a different kind of White person, different from the clinicians they had worked with before. I was distraught when participants described feeling "othered" in the therapy room. I constantly questioned if I should be the one to do this research. What had I done to deserve this honor of hearing these experiences besides expressing interest and writing a research proposal?

In these moments, I often reflected on a Ted Talk by one of my research mentors, Dr. Anneliese Singh. In her talk, *Trans Liberation is for Everyone*, she recalled being asked why she is an advocate for the rights of transgender people when she does not identify as trans (Singh, 2015). "So, why do you care so much about trans people?" she is asked (2015). Underneath that question, she explains, is an assumption that we should only care about those who are like us. "I do it because I care," Dr. Singh stated (2015). While I have watched this Ted Talk many times throughout the years, these words mean something different for me now. I cannot imagine a future in which I do not pursue this research, publishing it not only for eating disorder providers, but also for Latinx individuals. This research needs to be out there for those who feel isolated in treatment and those who wonder if they are the only ones in their communities battling Anorexia. It is impossible to picture not sharing this work, even within my own life, with colleagues, my community, friends and family. I am grateful and humbled at the opportunity to work with these participants and learn about their experiences. My hope is that this research and work moving forward can honor these participants' voices and change understandings around the value of cultural considerations in Anorexia treatment.

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APPENDIX A

Demographic Form

The purpose of this qualitative study is to examine the experiences of individuals who identify as Latinx who have participated in psychotherapy treatment for Anorexia Nervosa. Please complete the following demographic form. Thank you!

Pseudonym ______________ Age _______

Gender Identity ___________________________

Race _____________________________________

Ethnicity__________________________________

Country of Origin__________________________

Generation in the U.S. ______________________

Sexual Orientation _________________________

Marital Status_____________________________

Religious Affiliation ________________________

Practicing? (Please underline) Yes No

Socioeconomic Status ________________________

(e.g., middle class, lower class, lower middle, upper class, etc.)

Education Level ____________________________

(e.g., degree, Doctoral degree)

Current City of Residence ____________________

Length of time in treatment for Anorexia Nervosa _______

Age of Anorexia Nervosa Diagnosis ___________________

APPENDIX B

Interview Protocol

Treatment for Anorexia Nervosa with Latinx Clients: A Qualitative Inquiry

Interviewer: Interviewee: Date: Start time: End Time:

Hi, (pseudonym). My name is Amelia Hoyle and I am a doctoral student in the Counseling Psychology program at the University of Georgia. I am conducting my dissertation on Latinx clients' experiences of Anorexia Nervosa treatment. Specifically, I want to learn more about your cultural experiences of Anorexia Nervosa treatment. As a Latinx woman who has survived Anorexia Nervosa, you offer a unique perspective on eating disorder treatment. I appreciate you meeting with me today to talk more about that.

Before we begin the interview, I would like to remind you that the information you share during the interview will be kept confidential as explained in the consent form. I will not use your name or any other identifying information about you that might allow someone to figure out who you are. Feel free to skip any questions you do not want to answer and at any time you my end the interview. I anticipate the interview will take approximately one and a half hours. Though I will be asking you questions, if at any time you have questions throughout the interview, please feel free to ask. At this point, do you have any questions for me before we begin?

Rapport Building

1. Is there anything you need from me as an interviewer before we start with questions about your experiences with disordered eating and being in counseling or therapy?

2. What is your comfort level in discussing your experiences with disordered eating?

Background Information

3. Tell me about your first experiences with disordered eating.

Probing questions: How old were you at the time? What symptoms were your experiencing (bingeing, purging, restricting, etc.)? Did anyone have knowledge of your symptoms of disordered eating?

4. What led you to seek out treatment for Anorexia Nervosa?

Probing questions: Were your family/friends actively involved in your AN treatment? Were people in your life (friends, family members, significant others, etc.) aware that you were seeking counseling treatment?

5. Tell me about your experiences in counseling.

Probing questions: How long were you in treatment for (how many sessions)? What kind of setting did you attend for counseling services (inpatient, outpatient, etc.)? What were the demographics of the therapist? How many times have you attended therapy sessions for Anorexia Nervosa?

6. How did it feel to receive a diagnosis of Anorexia Nervosa?

Transition: As you were informed on the phone/e-mail, I asked you to think about two events in eating disorder treatment. These two events were sessions in eating disorder treatment in which cultural experiences were, for any reason, included. The first event is an experience in AN treatment in which you felt that your cultural experiences were positively included in treatment. The second event is an experience in which you felt your cultural experiences were not incorporated into treatment when it could have been beneficial for you.

It is not necessary that we stay with these two events specifically throughout our interview today. These events are simply helpful starting points in considering the ways in which cultural

experiences may or may not be included in Anorexia Nervosa treatment.

Events which might be helpful to discuss may include discussions in therapy of:

- Client-therapist cultural differences
- Racism
- Discrimination
- Oppression
- Acculturation
- Cultural values and strengths
- Intersecting of salient identities
- The misconception that people of color are "immune" to eating disorders
- What you would have liked to have been addressed in therapy surrounding culture

A list of these potential areas for discussion was included with your demographic sheet and may be consulted at any time during the interview.

Research Question #1

What are the cultural experiences of Latinx clients in eating disorder treatment for Anorexia Nervosa?

7. Please recall an experience in treatment for Anorexia Nervosa in which you felt that your experiences of being a Latinx woman were included into therapy in a beneficial way. As you feel comfortable, tell me about this experience?

Research Question #2

What perceptions do Latinx clients have regarding the cultural competence of therapists for the treatment of Anorexia Nervosa?

8. How do you feel your therapist demonstrated cultural competence in this session?

Probing questions: How did you know that your therapist was demonstrating cultural

competence? What did it look like? Tell me more about that? What is cultural competence to you?

Research Question #1

What are the cultural experiences of Latinx clients in eating disorder treatment for Anorexia Nervosa?

9. Please recall a different experience in treatment for Anorexia Nervosa in which you felt that your cultural experiences were not incorporated into treatment when it could have been beneficial for you. As you feel comfortable, tell me about this experience?

Research Question #2

What perceptions do Latinx clients have regarding the cultural competence of therapists for the treatment of Anorexia Nervosa?

10. What did it look like in therapy when your therapist was not demonstrating cultural competence?

Probing questions: How did you know that your therapist was not demonstrating cultural competence? What would this have looked like? Tell me more about that? What do you wish your therapist would have done at that time?

Transition: Are there other experiences in counseling that stand out to you in regard to the way that cultural considerations may or may not have been included in therapy? Would you care to share this additional experience?

Research Question #3

How do Latinx clients believe cultural factors played a role in engaging in treatment for Anorexia Nervosa?

11. How do you think race/ethnicity or your gender has impacted your view of your experience in treatment for Anorexia Nervosa?

Final Question: Though I have asked many questions of you, I want to give you the opportunity to share with me anything else that you would like to add. Is there anything you would like to share about your experiences of treatment for Anorexia Nervosa as a Latinx woman?

Wrap-Up: I want to thank you for sharing your experiences with me. I really appreciated your insight and time you spent with me today. If I have any follow-up questions later, may I contact you again?