Help seeking and barriers to treatment in a community sample of Mexican American and European American women with eating disorders

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Help Seeking and Barriers to Treatment in a Community Sample of Mexican American and European American Women with Eating Disorders

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ABSTRACT

Objective: The study examined treatment seeking for eating disorders in Mexican American and European American women.

Method: One hundred forty-five women with eating disorders (76 Mexican American, 69 European American) were diagnosed using the Structured Clinical Interview for DSM-IV-TR (SCID-IV) and Eating Disorder Examination (EDE).

Results: Only 28% of the sample reported having sought treatment for their eating problems and only 17% had received treatment. Both groups were equally likely to believe they have significant eating problems and to want help. However, Mexican Americans were less likely to have sought treatment and, having sought help, were less likely to have been diagnosed or treated. European Americans were more likely to have utilized psychotherapists, psychiatrists, and psychotropic medications, whereas Mexican Americans largely had sought help from general practitioners for weight concern. The two groups endorsed similar barriers to treatment seeking.

Conclusion: Results support clinical impressions that eating disorders largely go undetected and untreated. Nonspecialists may be likely to fail to detect eating disorders. © 2005 by Wiley Periodicals, Inc.

Keywords: barriers to treatment; eating disorders; ethnicity; health care utilization; treatment seeking

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Introduction

Eating disorders often go undetected or untreated, and women from racial or ethnic minority groups are especially likely not to access or receive care.1–3 This pattern is not unique to eating disorders. According to the report card published by the National Women’s Law Center,4 women of ethnic minority groups bear the greatest burden from unmet mental health needs. The report calls for research on women’s mental health needs and nonfinancial barriers to access to care. Recent studies have reported that Hispanic females may be as likely to experience eating disorder symptomatol-
counselor trustworthiness and understanding. Common system level barriers are financial difficulties and lack of health insurance; inaccessible health care facilities, time conflicts, and long waits; lack of transportation and lack of child care; and lack of bilingual staff that is representative of the Hispanic community. Two recent studies found racial/ethnic disparity in receiving treatment for an eating disorder. Among those who had sought care, proportionately fewer minority women actually received treatment than was true for White women.

The purpose of the current study was to examine correlates of treatment seeking in a community sample of Mexican American (MA) and European American (EA) women with anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), or eating disorder not otherwise specified (EDNOS). We predicted that treatment seeking would be associated with higher socioeconomic status (SES), more insurance coverage and better access to health care services, type of eating disorder, and/or presence of psychiatric comorbidity. We also predicted that compared with EA women, fewer MA women would have sought treatment or would have received treatment, that more MA women would have sought help from nonspecialists such as primary care providers or because of their weight, and that more acculturated MA women would be more likely than less acculturated individuals to have sought treatment.

This research was reviewed and approved by an institutional review board.

Method

Participants

Participants were 76 MA women (mean age = 27.8 years) and 69 EA women (mean age = 28.8 years, p = .40) with an eating disorder: 15 with AN (3 MA women, 12 EA women), 53 with BN (24 MA women, 29 EA women), 47 with BED (29 MA women, 18 EA women), and 30 with EDNOS (20 MA women, 10 EA women). These women had been recruited as part of a larger study by way of English and Spanish advertisements in local papers and flyers posted in stores and community organizations throughout the urban Los Angeles area. One half of the recruitment materials asked for MA or EA women to participate in a women’s health study, whereas the others specified a focus on eating problems. Interviewers blind to which type of flyer the participant had responded screened 454 individuals for eligibility (MA or EA women, 18–45 years old, not pregnant within the past 4 months). Fifty-one individuals were ineligible, 16 participants were omitted due to insufficient data, and 242 did not have an eating disorder.

Instruments and Procedure

Each woman participated in two phone interview sessions. Spanish-dominant participants (n = 25) were interviewed in Spanish by bilingual staff. Interviewers were trained until their ratings were in 100% agreement with an expert trainer’s (FMC) ratings on three consecutive interviews and participated in ongoing weekly supervision meetings. Phone interviews minimize barriers to participation and have been shown to generate Axis I and Axis II diagnostic information comparable to face-to-face interviews. Questions about demographics, insurance coverage, and treatment history were translated into Spanish and back-translated for accuracy using the method of Brislin. The interviews included the following components.

Demographics and Health Insurance Coverage. Participants reported ethnicity, country of birth, parents’ country of origin, age, level of education, and occupation. SES was calculated based on participants’ education and occupation according to Hollingshead’s two-factor index of social position. A lower score indicates higher social status. Participants were asked: “During the past five years were you covered by any health insurance?” “For how many months out of the past five years were you covered by health insurance?” “During the past 12 months, were you unable to obtain certain medical or psychological treatments because you had no insurance for these services or because you had exceeded the amount of coverage your insurance policy allows for these services?” “How about during the past five years?” “Given your current health care needs, are you satisfied with the health care services available to you in your community?” “Do you believe that you have adequate access to health care professionals in your community should you need them?”

Diagnoses. The Structured Clinical Interview for DSM-IV-TR (SCID-IV-TR) was used to determine Axis I disorders as defined in DSM-IV-TR. It has excellent reliability and validity in English and Spanish. Eating disorder diagnoses were based on the Eating Disorder Examination, 12th ed. (EDE), which has been shown to have high discriminant and concurrent validity and reliability in English and Spanish. Participants also were asked if they had ever believed they have a significant eating problem, wanted help for an eating problem, or sought treatment from a physician, counselor, or other health care provider for an eating problem or associated weight problem. Using self-reported height and weight, body mass index (BMI) was calculated (kg/m²).
Reasons for and Barriers to Seeking Treatment. Participants who indicated that they had sought treatment were asked the following questions: What did the treatment consist of? What diagnosis, if any, were they given? What was the age when they first sought treatment? What are the reasons for seeking treatment? Were they asked to endorse questions on barriers to mental health care utilization? Participants indicated on a 5-point Likert scale to what degree they agreed/disagreed with 19 possible reasons for not seeking help (see Table 3 for list of barriers). An example statement was: “I have not sought treatment for an eating problem because I have not known where to go.”

The Acculturation Rating Scale for Mexican Americans-II (ARSMA-II) was used to obtain a multidimensional measure of cultural orientation toward the Mexican culture and the Anglo culture among the MA women only and was sent via mail. The ARSMA-II has been shown to have high reliability and strong construct validity in English and Spanish.

Informed consent was obtained from participants and they were compensated monetarily. The protocol was approved by the institutional review board.

Results

Treatment Seeking

Even though 73.8% of the sample self-reported to have significant eating problems and 69% said they would like help, only 27.6% actually had sought professional help for their eating problems. MA women (73.7%) were as likely as EA women (73.9%) to believe they had significant eating problems, $\chi^2(1) = .001$, $p = .97$, and to want help (MA, 72.4%; EA, 65.2%), $\chi^2(1) = .86$, $p = .35$, yet significantly fewer MA women (27.6%) than EA women (44.9%) had sought treatment, $\chi^2(1) = 4.70$, $p < .03$. Overall, treatment seekers ($n = 52$) were more likely than nonseekers ($n = 93$) to believe they have a significant eating problem (86.5% vs. 66.7%), $\chi^2(1) = 6.81$, $p = .009$, and to want help (88.5% vs. 58.1%), $\chi^2(1) = 14.40$, $p = .000$. However, in ethnicity-stratified analyses, these differences were significant only for the EA group: EA treatment seekers ($n = 31$) were significantly more likely than nonseekers ($n = 38$) to believe they have an eating problem, $\chi^2(1) = 11.26$, $p = .001$; or to want help, $\chi^2(1) = 19.92$, $p = .000$. For MA women, there was no relation between treatment seeking ($n = 21$) or no treatment seeking ($n = 55$) and believing that one has an eating problem, $\chi^2(1) = .09$, $p = .76$; or wanting help, $\chi^2(1) = 1.07$, $p = .30$.

SES, Insurance Coverage, and Treatment Seeking

Two-factor (Ethnicity × Treatment seeking) analyses of variance (ANOVAs) were used to examine differences between the ethnic groups and treatment seekers versus nonseekers on SES and months of insurance coverage. The EA women ranked higher in SES (i.e., had a lower score) than the MA group ($M = 2.6, SD = 1.0$ vs. $M = 3.3, SD = 1.1$), $F(1, 143) = 11.36$, $p = .001$. There were no significant differences between treatment seekers and nonseekers on SES ($M = 2.8, SD = 1.0$ vs. $M = 3.1, SD = 1.2$), $F(1, 143) = .73$, $p = .39$, and there was no significant interaction effect, $F(1, 143) = .57$, $p = .45$.

Counts of health insurance coverage during the past 5 years were similar between the ethnic groups ($M = 36.5, SD = 25.2$ months for MA vs. $M = 41.7, SD = 21.3$ months for EA), $F(1, 144) = 1.67$, $p = .20$. Treatment seekers reported more months of insurance coverage than nonseekers ($M = 44.5, SD = 19.1$ vs. $M = 33.7, SD = 25.1$), $F(1, 144) = 7.08$, $p = .009$. There was no significant interaction effect, $F(1, 144) = 1.65$, $p = .20$. There were no differences between the ethnic groups or between treatment seekers and nonseekers on reported insurance denial, satisfaction with health services, or access to health care (data available upon request).

Ethnicity, Type of Eating Disorder, and Psychiatric Comorbidity

Most of the AN group was EA (80%), whereas 61.7% of the BED group and 66.7% of the EDNOS group were MA, $\chi^2(3) = 11.47$, $p = .009$. There was no relation between treatment seeking and eating disorder type, $\chi^2(3) = 3.29$, $p = .35$. Within diagnostic group comparisons found that MA women with BN (29.2%) were significantly less likely than EA women with BN (58.6%) to have sought treatment, $\chi^2(1) = 4.60$, $p < .03$. There were no ethnic differences in treatment seeking within the BED (24.1% MA vs. 38.9% EA), $\chi^2(1) = 1.15$, $p = .23$; EDNOS (25% MA vs. 40% EA), $\chi^2(1) = .71$, $p = .33$; or AN groups (66.7% MA vs. 25% EA), $\chi^2(1) = 1.87$, $p = .24$.

Psychiatric comorbidities were found in 75.6% of MA and 90.1% of EA. No significant relation was found between treatment seeking and mean number of psychiatric comorbidities (data available upon request).
Detection and Treatment

Among those (n = 52) who had sought treatment, 36.5% had received an eating disorder diagnosis and 46.2% had received treatment for an eating disorder. As predicted, EA women (51.6%) were significantly more likely than MA women (14.3%) to have been diagnosed, $\chi^2(1) = 7.52, p < .006$, or treated (61.3% vs. 23.3%), $\chi^2(1) = 7.08, p = .008$. Of 21 MA women who had sought help, only 5 had been diagnosed with or treated for an eating disorder (3 BN, 2 EDNOS). Among the EA women, those with AN and BN were significantly more likely than those with BED and EDNOS to have been diagnosed (100% of AN, 70.6% of BN, 14.3% of BED, 0% of EDNOS), $\chi^2(3) = 13.44, p < .004$, and treated (100% of AN, 82.4% of BN, 14.3% of BED, 25% of EDNOS), $\chi^2(3) = 13.81, p < .003$. MA women were significantly more likely than EA women to have been treated for a weight problem (57.1% vs. 23.3%), $\chi^2(1) = 6.04, p = .01$.

Types of Treatment

EA women were significantly more likely than MA women to have sought help from psychotherapists (67.7% vs. 28.6%), $\chi^2(1) = 7.70, p < .006$, and psychiatrists (41.9% vs. 14.3%), $\chi^2(1) = 4.49, p < .03$, and to have received psychotropic medications (45.2% vs. 9.5%), $\chi^2(1) = 7.46, p = .006$. The MA group was significantly more likely than the EA group to have received prescription diet pills (38.1% vs. 9.7%), $\chi^2(1) = 6.06, p < .01$. Analyses within diagnostic groups found that MA women with BN were significantly less likely than EA women with BN to have received psychotropic medications (25% vs. 70.6%), $\chi^2(1) = 4.59, p < .04$, and were somewhat less likely to have utilized psychiatrists (12.5% vs. 50%), $\chi^2(1) = 3.29, p = .08$. Analyses across diagnostic groups found that those with BED (37.5%) were significantly more likely than women in the other diagnostic groups to have been prescribed diet pills (4% of BN, 22.2% of EDNOS), $\chi^2(2) = 7.55, p = .02$ (AN were omitted due to small cell sizes). There were no differences between the ethnic groups for other types of professional services (Table 1).

Reasons for Seeking Treatment

Participants’ qualitative responses to why they had sought treatment were coded into six categories: concerns with eating, concerns with overweight, concerns with health, emotional distress, encouragement by friends and family, and treatment initiated by parents during childhood. More MA women (57.1%) than EA women (25.8%) reported that they had sought treatment because of a concern with weight, $\chi^2(1) = 5.19, p < .02$. The two ethnic groups did not differ on any of the other reasons (Table 2). Comparisons of diagnostic groups found no significant differences in seeking treatment for weight concern: 58.8% of BED, 28% of BN, 33.3% of EDNOS, $\chi^2(2) = 4.25, p = .12$; AN were omitted due to small cell sizes. Comparisons within diagnostic groups found that in the BED group, MA and EA women were equally likely to report weight concern (62.5% and 55.6%), $\chi^2(1) = .08, p = .78$. There were no ethnic differences for mean age of first seeking treatment (MA: $M = 20.4, SD = 9.0$ years; EA: $M = 19.6, SD = 5.5$ years), t(50) = .40, $p = .69$. Forty-two percent of treatment seekers (MA: 42.9%; EA: 46.4%), $\chi^2(1) = .06, p = .80$, reported that their initial treatment contact had made them unwilling to seek further help.

Barriers to Treatment Seeking and Acculturation

A multivariate analysis of covariance (MANCOVA; adjusting for SES) revealed no significant differences between the ethnic groups on endorsement of the various barriers to treatment seeking, overall $F(19, 88) = 1.08$, Pillai’s Trace = .19, $p = .38$.
The two groups endorsed similar impediments to treatment seeking (Table 3). The five barriers most strongly endorsed by MA women were feelings of shame, not knowing where to go for help, believing that one should be able to help oneself, fear of being labeled as having a disorder, and not believing that one’s eating problems are serious enough to warrant treatment. The five barriers most strongly endorsed by EA women were believing that one should be able to help oneself, not believing that one’s eating problems are serious enough to warrant treatment, feelings of shame, not knowing where to go for help, and finances or lack of insurance.

With regard to acculturation and treatment seeking in the MA women, there were no significant differences between treatment seekers (n = 21) and nonseekers (n = 55) on Anglo orientation (M = 4.0, SD = 0.4 vs. M = 3.8, SD = 0.6), t(73) = 1.22, p = .23, and only approached significance on Mexican orientation (M = 3.3, SD = 0.7 vs. M = 3.7, SD = 0.8), t(73) = 2.00, p = .05.

**Conclusion**

In the current study, we examined treatment seeking in a sample drawn from the community of MA and EA women with an eating disorder. To limit cultural heterogeneity, we focused specifically on women of Mexican origin rather than on Hispanics in general. MA constitute one of the largest and fastest growing populations in the United States.44 Most women, MA and EA alike, reported knowing they have significant eating problems (74%) and wanting help (69%). Yet, less than one third had ever sought treatment for their eating problems. As expected, the EA group was more likely than the MA group to have sought help. The ethnic difference in treatment seeking was not due to differences in psychiatric comorbidity or diagnostic severity. Indeed, the ethnic difference in treatment seeking was salient within the BN group.

Surprisingly, among the women who had sought treatment from a health care professional, less than 47% had received a diagnosis or treatment for the

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**Table 2. Comparison between Mexican American and European American women with eating disorders on reasons for seeking treatment**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Mexican American (n = 21)</th>
<th>European American (n = 31)</th>
<th>χ²(1)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern with overweight</td>
<td>57.1% (12)</td>
<td>25.8% (8)</td>
<td>5.19</td>
<td>.02*</td>
</tr>
<tr>
<td>Encouragement of friends</td>
<td>23.8% (5)</td>
<td>35.5% (11)</td>
<td>.80</td>
<td>.37</td>
</tr>
<tr>
<td>Concern with eating</td>
<td>9.5% (2)</td>
<td>25.8% (8)</td>
<td>2.14</td>
<td>.14</td>
</tr>
<tr>
<td>Initiated by parents</td>
<td>19.0% (4)</td>
<td>22.6% (7)</td>
<td>.99</td>
<td>.76</td>
</tr>
<tr>
<td>Emotional distress</td>
<td>4.8% (1)</td>
<td>22.6% (7)</td>
<td>3.05</td>
<td>.12</td>
</tr>
<tr>
<td>Health concerns</td>
<td>9.5% (2)</td>
<td>12.9% (4)</td>
<td>.14</td>
<td>1.00a</td>
</tr>
</tbody>
</table>

**Table 3. Comparison between Mexican American and European American women with eating disorders on endorsement of barriers to treatment seeking**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Mexican American (n = 60)</th>
<th>European American (n = 49)</th>
<th>f(1, 108)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>3.8 (1.5)</td>
<td>3.5 (1.4)</td>
<td>1.38</td>
<td>.24</td>
</tr>
<tr>
<td>Not knowing where to go</td>
<td>3.7 (1.5)</td>
<td>3.4 (1.4)</td>
<td>1.56</td>
<td>.21</td>
</tr>
<tr>
<td>Believe should help self</td>
<td>3.5 (1.6)</td>
<td>3.7 (1.3)</td>
<td>.59</td>
<td>.44</td>
</tr>
<tr>
<td>Fear of labeling</td>
<td>3.4 (1.6)</td>
<td>3.2 (1.5)</td>
<td>.72</td>
<td>.40</td>
</tr>
<tr>
<td>Problem not serious enough</td>
<td>3.4 (1.6)</td>
<td>3.5 (1.4)</td>
<td>.25</td>
<td>.62</td>
</tr>
<tr>
<td>Finances</td>
<td>3.2 (1.7)</td>
<td>3.2 (1.6)</td>
<td>.000</td>
<td>.99</td>
</tr>
<tr>
<td>Unaware of treatments</td>
<td>3.2 (1.5)</td>
<td>3.0 (1.5)</td>
<td>.70</td>
<td>.41</td>
</tr>
<tr>
<td>Lack of trust in providers</td>
<td>3.0 (1.5)</td>
<td>2.9 (1.4)</td>
<td>.33</td>
<td>.57</td>
</tr>
<tr>
<td>Turn to other sources</td>
<td>2.8 (1.4)</td>
<td>2.7 (1.4)</td>
<td>.09</td>
<td>.76</td>
</tr>
<tr>
<td>Lack of support</td>
<td>2.7 (1.4)</td>
<td>2.6 (1.4)</td>
<td>.23</td>
<td>.64</td>
</tr>
<tr>
<td>Providers lack expertise</td>
<td>2.5 (1.4)</td>
<td>2.4 (1.3)</td>
<td>.004</td>
<td>.95</td>
</tr>
<tr>
<td>ED not psychological problem</td>
<td>2.4 (1.6)</td>
<td>2.4 (1.5)</td>
<td>.000</td>
<td>1.00</td>
</tr>
<tr>
<td>Fear of discrimination</td>
<td>2.4 (1.5)</td>
<td>2.0 (1.3)</td>
<td>1.90</td>
<td>.17</td>
</tr>
<tr>
<td>Providers not same background</td>
<td>2.3 (1.4)</td>
<td>1.8 (1.1)</td>
<td>3.97</td>
<td>.05</td>
</tr>
<tr>
<td>Fear of separation from family</td>
<td>2.0 (1.4)</td>
<td>1.8 (1.0)</td>
<td>.64</td>
<td>.42</td>
</tr>
<tr>
<td>Child care</td>
<td>1.9 (1.5)</td>
<td>1.8 (1.1)</td>
<td>.37</td>
<td>.55</td>
</tr>
<tr>
<td>Use alternative treatments</td>
<td>1.9 (1.4)</td>
<td>2.2 (1.3)</td>
<td>1.73</td>
<td>.19</td>
</tr>
<tr>
<td>Transportation</td>
<td>1.7 (1.1)</td>
<td>1.6 (1.1)</td>
<td>.16</td>
<td>.69</td>
</tr>
<tr>
<td>Language barrier</td>
<td>1.5 (1.0)</td>
<td>1.4 (1.0)</td>
<td>.07</td>
<td>.79</td>
</tr>
</tbody>
</table>

Note: Mean scores presented are based on a 5-point Likert scale, with 1 = strongly disagree and 5 = strongly agree. ED = eating disorder.

Note: Qualitative responses were coded into categorical variables (yes/no). Percentages represent the number of individuals within each ethnicity. Some participants provided more than one reason.

*Fisher’s exact test.

*Significant between-group difference at p < .05.
eating disorder. It would appear that the opportunity to detect and treat presenting eating disorders was largely being missed and this was particularly true for the MA women. Similarly, a recent large-scale study of eating disorders on college campuses found that even after adjusting for symptom severity and other factors such as BMI, Latinas were still less likely to be referred for further evaluation of eating concerns than were Whites, and physicians were less likely to inquire about eating disorder symptoms if the participant was of an ethnic minority. It is notable that this disparity in access to care existed despite homogeneity between ethnic minority and nonminority individuals with respect to education and access to college-affiliated health services.

Financial difficulties and lack of insurance, although endorsed by both ethnic groups, were not the primary barriers reported by the women in our study. Research indicates that availability of health insurance does not necessarily promote greater contact with mental health services. Person factors such as motivation, knowledge of resources, and feelings of shame seem to be prominent influences as well.

There was some relation between type of eating disorder, ethnicity, and likelihood of detection and treatment. Among the group of EA women who had sought help, those suffering from AN or BN were significantly more likely to have been diagnosed and treated for an eating disorder than those suffering from BED or EDNOS. For the MA group, there was no relation between type of eating disorder and likelihood of detection and treatment. A total of only 5 MA women had been diagnosed or treated. Our findings support other research indicating that in samples that present for professional care, AN is readily detected. Nevertheless, our findings also demonstrate that in a community sample, the majority of women with AN have not sought treatment.

We did find differences between the ethnic groups for types of treatment. EA women were more likely than MA women to have sought help from specialists such as psychotherapists and psychiatrists, and to have received psychotropic medications. In particular, MA women with BN were less likely than their EA counterparts to have received antidepressants or help from psychiatrists. Conversely, MA women had sought help primarily from general practitioners and were more likely to have received prescription diet pills, which could be attributed to the larger proportion of BED in this group. The majority of MA women who had sought help had not been diagnosed with or treated for their eating disorder. More than one half, however, had been treated for a weight problem. It appears that nonspecialists may be especially likely to fail to detect and treat eating disorders, particularly in women of ethnic minority groups.

The reasons provided by both ethnic groups for seeking treatment were concern with overweight, concern with eating, encouragement of friends and family, emotional distress, health concerns, and treatment initiated by parents. MA women were more likely than EA women to have sought help because of concern with overweight. This difference again may be due to the larger proportion of BED in the MA sample. The fact that obesity is a growing health problem in the MA community is recognized. However, knowledge that this population suffers from eating disorders where binge eating is a key behavioral symptom may not be widely shared. If MA women are presenting to their general care physicians primarily with weight concerns, then they are contributing to the under-detection of eating disorder symptoms. It seems that both physicians and patients need to be educated about eating disorder symptomatology in ethnic minority populations. Physicians need to be aware that the presence of overweight or obesity may be indicative of an eating disorder in this population.

The most strongly endorsed reasons for not seeking treatment were feelings of shame, not knowing where to go for help, believing one should be strong enough to help oneself, minimization of the seriousness of the problem, fear of being labeled, financial or health insurance concerns, and being unaware of the treatments available. An additional barrier for the EA women was not feeling one has an eating problem (which is common in AN). There was no relation between believing one has a problem and seeking treatment for the MA women. Regardless of how they felt, few had sought treatment. Among the MA women, we also found no significant relation between acculturation to U.S. society and treatment seeking, although the mean trends were in the predicted direction. Our sample’s mean level of acculturation was very similar to the normative sample of the ARSMA-II, suggesting that our lack of an effect of acculturation does not arise from unusual acculturation scores. Our sample of MA treatment seekers may have been too small and future studies are needed that examine this relation more closely using larger samples with a wide range of acculturation levels.

The limitations of our study included the small sample of MA women who had been treated for an eating disorder, limiting statistical power for some

Int J Eat Disord 39:2 154–161 2006
analyses and precluding, for example, statistical tests on the relation between the type of eating disorder and detection or treatment for this group. A further limitation was the self-report nature of the data on treatment seeking, which may have been subject to biases in recall. As would be expected, there was comorbidity with depression and anxiety disorders in our sample. Although participants were specifically asked about help seeking and treatment for eating disorders, there might have been overlap between treatment for the eating disorder and treatment for other mental health problems. Finally, this was a “convenience sample.” Therefore, we cannot provide prevalence data for eating disorders in the MA community and our results may not generalize to other regions. These limitations are offset by several strengths, including the recruitment of women from the community, the inclusion of an ethnic minority population that has been largely neglected in eating disorder research, and the use of research interviews administered by highly trained staff.

Our results support clinical impressions that eating disorders largely go undetected and untreated. A great deal more educational outreach is needed to help women, particularly those from ethnic minority groups, obtain treatment for eating disorders.

References
