An exploration into the experience of an eating disorder and journey into treatment for British South-Asian women: What can we learn?

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by

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Declaration

This thesis is an original piece of work that has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

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Thank you to the participants who shared their stories with me. Without them, this research would not have been possible, and I hope that I have done justice to their accounts.

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	Without Appendices	Appendices (with references)
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Critical Appraisal:	3,371	
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Thesis Abstract

An exploration into the experience of an eating disorder and journey into treatment for British South-Asian women: What can we learn?

Shana Hoque
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A relatively large body of research has highlighted the high (or equal) risk of disordered eating in South-Asian populations in comparison to Caucasians, particularly in the UK.
The literature review aimed to examine the empirical evidence for eating disorders and body dissatisfaction in South-Asian populations over the past decade. Through systematic searching a total of 16 studies were identified that met the inclusion criteria. These studies, not without limitations, highlighted the high level of disordered eating in young South-Asian populations compared to disordered eating in other ethnicities. The finding of higher body dissatisfaction in more Westernized South-Asian populations was also evidenced.

Despite the findings that South-Asians are at equal risk as other ethnic groups for eating disorders, they remain under-represented in treatment services in the UK. The aim of the research report was to explore the eating disorder experience and journey into treatment for British South-Asian women who were in treatment in eating disorder services. Interpretative Phenomenological Analysis was used to analyse the transcripts from six participants. Three overarching themes emerged: the critical Asian society; the parental response: rejecting, tolerating and accepting; and the role of self and voicing needs. Implications for eating disorder services were made based on the experiences of these participants.

The critical appraisal was an account of the research journey. Specifically, it highlighted the difficulties encountered along the process and how the present researcher managed these. It also incorporated the dilemmas for the present researcher in using a qualitative methodology.

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(Excluding abstract & tables)

1. Abstract

An examination of the evidence for eating disorders and body dissatisfaction in South-Asian Populations

Shana Hoque

Introduction: Previous research has indicated the risk of British-South Asian young women for disordered eating. One study indicated higher prevalence rates for bulimia nervosa in British South Asian girls compared to Caucasian peers. Despite these figures, there have been no published reviews examining the strength of evidence for eating disorders in British South-Asian populations.

Method: A systematic literature search was conducted across five databases: PsychInfo, Psycharticles, Web of Science, Medline and Scopus. Inclusion criteria specified that: studies had to date from 2001; explicitly state that the population was South-Asian; and eating disorders and/or body dissatisfaction had to be formally measured. Sixteen studies were included in the review from the 240 that were identified.

Results: Few studies have examined the prevalence of eating disorders in South-Asians, and only one study in the current review attempted to do so. The majority of studies focused on the presence of eating disorder symptoms in South-Asians. A higher incidence of eating disorder symptoms were reported for South Asians (particularly those who were British) in comparison to other ethnic groups. There was clearer evidence for higher levels of body dissatisfaction in more Westernized South-Asians compared to those with less exposure to Western values. Teasing by peers was implicated in the development of body dissatisfaction and eating pathology in South-Asians.

Conclusions: Limitations of the reviewed studies included lack of measurement of socio-economic status, small sample sizes and questionable applicability of measurement tools. Future research recommendations are discussed.

2. Introduction

Eating disorders (ED) were once considered 'culture bound syndromes' affecting only young affluent Western women (Bruch, 1973; Prince, 1983). However, since the 1980s, published studies from across the world including Nigeria (Nwaefuna, 1981), Zimbabwe (Buchan & Gregory, 1984) and Malaysia (Buhrich, 1981), have reported cases of ED. Furthermore, ED have been thought to occur in other parts of the world, such as Japan, as early as the 18th Century (Nishizono-Maher, Miyake & Nakane, 2004).

The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM-IV-TR*]; American Psychiatric Association, 2000) defines three types of ED: anorexia nervosa (AN), bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS). Anorexia nervosa is characterised by low body weight, a fear of becoming fat and body image distortion. In bulimia, low weight is not necessarily present, but binging and purging as well as body image distortion are features. Eating disorders that do not meet the full criteria of either diagnosis are categorised as EDNOS. The issue of whether eating disorders, globally, present according to these criteria is well debated (e.g. Lee, Tp & Hsu, 1993).

Prevalence rates of eating disorders have been shown to vary by ethnicity (Brown, Cachelin & Dohm, 2009). For instance, Hoek and van Hoeken (2003) estimated the prevalence of AN to be 0.3% and 1% for BN in Caucasian adolescents. Striegel-Moore et al. (2003) reported prevalence rates of 1.5% in Caucasian women for AN and 2.3% for BN. However, in Black women, Striegel-Moore et al. (2003) reported a prevalence of 0.0% for AN and 0.4% for BN. In Asian women, the prevalence of AN and BN was reported to be 0.12% and 1.42% respectively (Nicdao, Hong and Takeuchi, 2007) and Alegria et al. (2007) reported

prevalence rates of 0.12% and 1.91% for AN and BN in Hispanic women. These statistics form the basis of the argument that ED occur less in non-Caucasian populations.

It was thought that certain cultures would be protected against the development of ED, particularly African and Asian cultures where poverty is rife and therefore fuller and healthier figures are valued as they are considered to be equated with fertility and prosperity (Furnham and Baguma, 1994). However, given the rising number of ED reported across the world, there is now an argument that Western beauty ideals of slimness have infiltrated and led to a global increase in eating disorder pathology (e.g. Nasser, 1997).

Brown et al. (2009) reviewed the evidence of eating disorders in ethnic minority women and reported evidence for BN and Binge Eating Disorder (BED) in Black women, however AN was rare. They also noted that Black women with BED had a higher frequency of binge episodes and a higher rate of obesity than other ethnicities. Brown et al. (2009) suggested that for Black women, their lower concern with weight and shape may reflect less drive for thinness, which in turn would be less of a developmental factor in the eating disorder compared to Caucasian women. Likewise, Hispanic women were also shown to suffer with eating disorders, and reported worse binge eating behaviour than Caucasians. For Asian women, evidence of bingeing was reported, but there were fewer purging behaviours. Overall, Brown et al. (2009) concluded that there was evidence of disordered eating in all ethnic groups, but whilst drive for thinness and body dissatisfaction were relevant in the development of some eating disorders, they were less of a factor in some cultures.

However studies that have examined disordered eating rather than eating disorders according to *DSM* (American Psychiatric Association, 1987; 2000) criteria, report much higher rates in

ethnic minorities. Regan and Cachelin (2006) found similar levels of binge eating in Asian, Hispanic, Black and Caucasian populations, as well as high level usage of diuretics, laxatives or pills in Black women, but lower levels in Asian women.

Body dissatisfaction (BD), the negative thoughts and feelings people have about their body and appearance (Grogan, 1999), is an important diagnostic concept in eating disorders (*DSM-IV-TR,* 2000). The link between BD and ED is well established, as women with high body dissatisfaction will be more likely to engage in maladaptive eating behaviours to alter their bodies (Cash & Deagle, 1997).

In a review focused on BD across cultures, Holmqvist and Frisen (2010) found that BD was more pronounced in economically developed Western countries (e.g. USA, Canada, Australia, Western Europe). However, Holmqvist and Frisen (2010) also reported that Westernized Asians seemed to value being thin and exhibited greater BD than people in the USA in some studies (Davis & Katzman, 1998). Also slimness was claimed to be valued by females globally (Jaeger et al., 2002).

In a review examining BD and ED, Soh, Touyz and Surgenor (2006) reported divergent findings when comparing BD and disordered eating across ethnic minorities within Western nations. Some studies reported no difference in disordered eating (French et al. 1997) and others reported higher levels of BD and eating disturbance in minority groups (e.g. McCourt & Waller, 1995). Soh et al. (2006) noted the difficulty in the term 'culture' and how within a particular ethnic group, there are variations in language, class, place of residence, clothing choice, immigration status, number of generations preceding etc. They also discussed how few studies had been conducted in the country of origin for the particular ethnic group under

investigation, and the inconsistent measurement of acculturation, the degree to which another culture's values, attitudes and society standards have been adopted by an individual from a different culture (Berry, 1986), thus making comparison of studies difficult.

A consistent theme across the cross-cultural reviews into eating and body image disturbance, is the way in which ethnicity is defined. The use of the term Asian, has been particularly problematic in the research area. In their review of ED in Asian populations, Cummins, Simmons and Zane (2005) discussed how most research conducted in the USA uses the term Asian to refer to groups from Eastern Asia (e.g. Chinese & Japanese), though at times it can refer to people from Southeast and other parts of Asia. In the UK, Asian typically refers to groups from the Indian subcontinent. Therefore research reporting findings about Asian populations, without specifying which part of Asia, can lead to inconclusive or erroneous results. For example studies of British Indian girls demonstrate similar rates of BD and more disordered eating behaviour than Caucasian girls (Mumford, Whitehouse & Platts, 1991). However, although Asians in the USA reported as great BD as Caucasian counterparts, Caucasians were more likely to engage in purging compensatory behaviours (Nevo, 1985). Also, given that numerous studies since the 1970s have highlighted sociocultural factors in the aetiology of eating disorders, it is important to be able to delineate these factors, and examine how they vary, or not, across ethnic groups.

The evidence for disordered eating, BD and ED in South-Asian women, particularly those resident in the UK is striking. Marshall and Yazdani (2000) defined South-Asian as people originating from the subcontinent of India, Pakistan, Bangladesh, Sri Lanka and East Africans Indian in origin. Dolan, Lacey and Evans (1990) found South-Asian women presented with significantly more disordered eating compared to Afro-Caribbean and

Caucasian women attending a family planning clinic. Mumford, Whitehouse and Platt (1991) found a higher prevalence of BN in South-Asian girls (3.4%) compared to Caucasian girls (0.6%) in a sample of 559 using the *DSM-III-R* (APA, 1987) criteria. Various hypotheses have been offered to account for these findings including higher levels of cultural conflict: that is those who are more acculturated into British culture, but living in traditional family environments (McCourt & Waller, 1996). The process of acculturation and its link to eating disorder pathology in ethnic minority women has received empirical support from studies conducted in India and Pakistan (Mumford, Whitehouse & Choudry,1992; Sjostedt, Schumaker & Nathawat, 1998).

Findings from other studies have reported divergent results. Ogden and Elder (1998) measured body image and eating behaviour in Caucasian and South-Asian mother-daughter dyads. Ogden and Elder (1998) found no relationship between acculturation, body image and eating behaviour in South-Asians. South-Asian girls showed greater body satisfaction and less calorie concern compared to Caucasian girls. The authors suggested that high levels of BD and calorie concern in Caucasian girls may have related to overexposure to thin Caucasian women in the media, whereas for South-Asian girls, their ethnicity may have worked as a protective factor, as these girls may not have identified with Caucasian women portrayed in the media.

Awareness of the complications of not delineating between ethnic groups has been growing, as demonstrated by review articles focused on body image and eating disorders in specifically Japanese adolescents (Chisuwa & O'Dea, 2009), and Black women (Striegel-Moore et al, 2003). To the current author's knowledge, there have been no published reviews focusing on body image and eating disturbances in specifically South-Asian people. Cummins et al.

(2005) examined South-Asian samples within their review of eating disorders in Asian populations, however only studies published up until 2001 were included, thus there has been a decade of published research since that review. Also, the more recent reviews (e.g. Brown et al., 2009) examining ethnicity, BD and ED have been published by American authors and therefore mostly include East Asian populations. Furthermore Cummins et al. (2005) predominantly assessed the evidence for disordered eating, however, there are numerous studies that examine both body image and eating disorder constructs. Also, body image distortion remains a key feature of eating disorder diagnosis. Therefore a review of the literature exploring both BD and ED in South-Asians was considered to be pertinent by the present author, particularly given that South-Asians form 4% of the UK population (OPCS, 2001) and previous research suggests that they are a high risk group for eating pathology.

2.1. Aims

The aim of the present review was to assess the evidence for eating disorders (ED) and body dissatisfaction (BD) in South-Asian women by examining the published research over the past decade. It addressed the following questions:

1. How strong is the evidence for eating disorders and body dissatisfaction in South-Asian women, and how should future research address the limitations of the current literature?

2. What are the treatment implications for eating disorder services?

3. Method

3.1. Literature Search Strategy

The present study followed on from the published review of ED in Asian populations by Cummins et al. (2005). As the date of the last South-Asian population study included in the Cummins et al. (2005) review was 2001, the present review searched for studies post 2001. Studies were identified through keyword searches in PsychINFO, PsychArticles, Web of Science, Medline and Scopus (2001- to March 2011). Reference sections from previous review articles were searched for additional references, as were major journals for eating disorders and body image. Despite Cummins et al. (2005) not including clinical samples in their review due to low referral or underutilisation by ethnic minorities to mental health services (Waller et al, 2009), the present review did include studies with a clinical population, in order to understand how South-Asian women may differ in the nature of their eating disorder from other ethnicities.

3.2. Inclusion Criteria

Studies were included if they met the following criteria:

- Studies included a South-Asian population as defined by Marshall and Yazdani (2000).
- Clinical eating disorders, disordered eating and/or body dissatisfaction were formally measured.
- Studies were published after 2001 (or not included in the Cummins et al. (2005) review if published in 2001).

A key word search combining the words: eating disorder, anorexia, bulimia, EDNOS, body dissatisfaction, body image, thin ideal, restrict, diet or weight with British Asian, South Asian, Pakistani, Bangladeshi, Indian and Sri Lankan generated 42 articles. Studies were excluded for the following reasons: they recruited Asian populations, but did not specify ethnicity beyond, studies focused just on men or measured body dysmorphic disorder, studies were not published in English or studies focused on obesity and body dissatisfaction in populations with high BMI[1]. Thirteen relevant articles met the inclusion criteria.

A separate search combining the keywords: culture and ethnicity with the above search criteria generated 198 results. These key words were included to ensure that any studies that included a South-Asian sample (but not included as a keyword) were not missed. Results were carefully searched through to see if there were any additional studies to include in the review (using the same exclusion criteria). Three additional studies were identified. A total of 16 studies therefore were included in the literature review.

[1] Body Mass Index

4. Results

4.1. Eating disorder symptoms in South-Asians in clinical settings

Two studies, both case-note reviews, examined eating disorder symptoms in clinical settings (see Table 1 below).

Table 1. Eating disorder symptoms in South-Asian clinical populations

Study	Country	Population	Sample	Measures	Findings
Abbas,Damani, Malik, Button, Aldrige & Palmer (2010)	UK	Leicester Adult Eating Disorder Service - Clinical population	2070 patients in total from 1991 to 2005, 95 (4.6%) were Asian and 1975 (95.4%) non-Asian.	CEDRI[2]: Age, BMI, duration of ED, self induced vomiting, laxative abuse, self defined binge eating, loss of control fantasy –weight, loss of control fantasy eating, guilt/disgust, weight/eating, total Out Patient sessions, CBT offered, IPT, Guided Self Help, other therapy offered.	75 Asians met criteria for ED; 6 met criteria for AN (not included in comparisons); 26 with BN and 43 for EDNOS. Overall rate of Asian females is about a 1/3 expected. Asian patients were about 4 years younger than non-Asians There were no significant differences in clinical symptoms between Asian and non-Asian women.
Tareen , Hodes & Rangel (2005)	UK	Clinical population	Patients were identified from four CAMHS clinics in West London from 1992 onwards. 14 SA patients – 15.07 years 14 Whites patients – 14.97 years	Proforma used to record basic demographics, family and personal characteristics, details of weight, eating pathology and related behaviours. Morgan-Russell Socio-Economic Subscale	SA more likely to describe loss of appetite and less likely to describe fat phobia compared with White counterparts.

[2] See Appendix C for description of all measurement tools with references

Abbas et al. (2010) examined South-Asian patients referred to a UK Adult Eating Disorder service from 1991 to 2005 to establish referral rate and assess whether symptoms in South-Asian clients differed from Caucasian clients using the CEDRI[3]. Abbas et al. (2010) reported that seventy-five South-Asian women met the criteria for an eating disorder (ED), six for AN (who were not included in further analyses), 26 for BN and 43 for EDNOS. The authors estimated that the number of South-Asian females (4.5%) in that age group presenting to the treatment service was about a third of what would be expected for South-Asians (according to South-Asian population in catchment area). Clinical symptoms between the patients were compared, and no significant differences on any of the variables were found which suggested that South-Asian women seeking treatment for ED closely resembled their non-Asian counterparts in their presentations.

Tareen, Hodes and Rangel (2005) investigated the clinical features of 14 South-Asian female adolescents, matched to Caucasian peers, who presented to Child and Adolescent Mental Health Services (CAMHS) with low weight (BMI <18). They found that for the South-Asian girls with AN they exhibited less fear of fatness than Caucasians, and were significantly less likely to exercise to control weight and to be preoccupied with food, but more likely to present with loss of appetite. The authors suggested that lack of 'fat phobia' may be related to generally less negative views of body fat in this population. They also hypothesised that as South-Asians are from a collectivist culture, the view of the self for these participants may have been 'relational' thus preventing the expression of individualistic ideas.

The above two studies presented divergent findings, with Tareen et al. (2005) reporting significant differences between South-Asian and Caucasians clients with AN, whereas Abbas

[3] Clinical Eating Disorders Rating Instrument

et al. (2010) found no significant differences between the two groups. It should be noted that the two populations differed in age, and also by diagnosis, as those with AN were excluded from the Abbas et al. (2010) study. Also, both studies included relatively small sample sizes so findings should be interpreted with caution. Furthermore, Tareen et al. (2005) used a proforma to assess for differences between ethnic groups, not standardized measures or a structured interview, therefore it was difficult to get a sense of how 'fear of fatness' was measured. One possibility to account for absence of 'fear of fatness' in adolescents, is that it may become more relevant as age increases. 'Fear of fatness' could be exhibited in adulthood when height is more static and weight continues to increase.

4.2. Prevalence of eating disorders in South-Asians

One study (Suhail & U-Nisa, 2002) conducted in the Indian subcontinent examined the prevalence of ED in South-Asians (see Table 2 below) using a two stage process.

Table 2. Prevalence of eating disorder symptoms in South-Asians

Study	Country	Population	Sample	Measures	Findings
Suhail & U-Nisa (2002)	Pakistan	University students	111 postgraduate women from the Punjab University Government College, Lahore.	Dissatisfaction with weight EAT-26 Body Shape Questionnaire (BSQ) Hospital Anxiety and Depression scale Media Exposure Interview and the DSM-IV criteria for eating disorders	Two women met criteria for BN and two met criteria for EDNOS. Prevalence: 1.8% for BN and 3.6% for EDNOS. Dissatisfaction with weight had a significant correlation with BMI. 59% of participants were of normal weight and 21% of underweight women were discontent with current size. Non-sig correlation between EAT and BMI suggests that problematic eating attitudes are only slightly influenced by being actually overweight.

Cummins et al. (2005) discussed how the establishment of an eating disorder requires a face to face interview using a structured tool such as *DSM-IV-R* (APA, 2004). This is a time consuming method for research and there are difficulties associated with applying changeable criteria that have been standardized on Western populations, therefore most research has focused on establishing prevalence rates of ED using a two stage process (Cummins et al. 2005) in that a screening measure for ED is used, and those who score above the clinical range are interviewed.

Suhail and U-Nisa (2002) reported prevalence figures of 1.8% and 3.6% for BN and EDNOS respectively in their sample of Pakistani postgraduate women. Results also showed that 50% of the normal weight Pakistani women regarded themselves as overweight. However there was no correlation between EAT-26[4] scores and BMI[5], suggesting that abnormal eating was independent of BMI. Finally, the women who showed greater dissatisfaction with body shape were more dissatisfied with their weight. The authors found that the girls who watched more TV (a measure of media exposure) showed greater unhealthy eating patterns and more concern about body shape.

Suhail and U-Nisa (2002) found no cases of AN, however, it is not possible to determine whether absence of AN relates to failure to meet particular diagnostic criteria of AN, like fear of fatness which Tareen et al. (2005) noted to be absent in the British South-Asian girls with AN, or a lack of the disorder itself. There are a number of limitations with Suhail and U-Nisa's (2002) study including the university student sample who were likely to be representative of a higher SES[6]. Also, two participants who scored above the cut off and

[4] Eating Attitudes Test- 26
[5] Body Mass Index
[6] Socio-Economic Status

were invited to interview declined (from the eligible 14), therefore prevalence rates could have potentially been biased. Finally the measure of media exposure – number of hours spent watching satellite TV was quite crude and does not help to delineate exactly what messages are particularly affecting the women who observed them.

4.3. Prevalence of eating disorder symptoms in South-Asians compared to other ethnic groups.

The most common way of assessing for eating disorder prevalence is to focus on the prevalence of eating disorder symptoms (such as binge eating, purging and body image), and the profiles of symptoms within particular groups (Cummins et al. 2005) . Research has documented the relationship between these factors and the development of ED (Stice, 1999). Four studies compared the prevalence of eating disorder symptoms in South-Asians to other ethnic groups. South-Asian participants were recruited from the UK, USA, Indian subcontinent and Oman. Two studies compared minority groups residing in the same country (Bhugra & Bhui, 2003; Thomas, James and Bachman, 2002), and two studies compared groups across several countries (Rubin, Gluck, Knoll, Lorence and Geliebter, 2008; Kayano et al., 2008). A total of 351 South-Asian participants were included in the four studies ranging in age from 11-22 and were either Pakistani or Indian in origin (See Table 3. below for details of studies).

Table 3. Prevalence of eating disorder symptoms in South-Asians compared to other ethnic groups

Study	Country	Population	Sample	Measures	Findings
Bhugra & Bhui (2003)	UK	High School students in East London school	134 = White 51 = Black 52 = Asian 29 = Other	A modified version of BITE (Bulimia Investigation Test Edinburgh) Questions on acculturation were adopted from El-Islam Qualitative Interview DSM-III-R interviews for ED	Asians had the highest BITE scores compared with the other three groups, suggesting they may be suffering from abnormal eating. Bulimic scores were similar across ethnic groups, but the pattern of subclinical bulimic behaviours varied across groups.
Rubin, Gluck, Knoll, Lorence & Geliebter (2008)	USA, France, India & Tibet	Female students from middle and high schools	USA –n= 90, from one public (62) and one private high school (28) France n = 30 high school girls India = 40 (school in New Delhi) Tibet = 60 (central and middle schools in Lhasa)	EAT The Figure Rating Scale The Beck Depression Scale Additional questions were composed by the authors to assess religiosity, empowerment, drug and alcohol use, media exposure and perceived barriers to success.	Girls in US did not differ in eating disorder pathology and depression from girls in France and India, both before and after controlling for age, SES and BMI. Girls from the high SES area of India were equally as likely to exhibit eating psychopathology regardless of their non-Western location Religiosity was higher in India than US or France, yet they still had similar eating disorder or depression scores. SES appeared to play a large role in eating disordered pathology given that those in India had highest SES.

Kayano et al., (2008)	Oman, Japan, Phillipines	High school students	130 Indian – residing in Oman attending an Indian school. 113 Euro-American (US, British and Western European attending English language school in Oman) 196 Filipino (recruited from schools in Manila metropolitan area in the Philippines) 411 Japanese (recruited from four vocational schools in Japan) 135 Omani (recruited from three schools in Muscat, Oman)	EAT-26 Drive for Thinness, subscale of EDI-II	Among females, Indians and Filipinos had greater dysfunction in eating attitudes compared to Europeans. Indians had higher 'bulimic eating behaviour' and 'control over eating'. As BMI increased there was a decrease in abnormal eating patterns in Indian female subjects. DT less striking in Indian, Omani and Filipinos – consistent with previous studies.
Thomas, James & O Bachmann (2002)	UK	High school students	429 were White (59.4%) 117 Black/African Caribbean (16.2%) 129 Asian/Muslim (17.9%) Mixed race 19 (2.6%) Other 28 (3.9%) 11-16 year olds	EAT-26 Rosenberg self-esteem questionnaire Angold Mood and Feelings questionnaire	Asians had more severe EAT scores at severe and lower end (>10). A plausible explanation is that Asians may face internal conflict as they grow up with two sets of cultural values and live in families that adhere to more traditional values.

Two studies compared British South-Asian to other minority groups: Bhugra and Bhui (2003) administered the BITE[7], as well as a measure of acculturation, and randomly interviewed 1 in every 10 participants using the *DSM-III-R* (1987). Overall, no participants met the criteria for BN, however South-Asians were reported to have the highest BITE scores. Using Caucasian participants as the reference group, the authors found that South-Asians were more likely to 'keep fasts', 'feel that food dominated their lives', 'think about food' and 'eat sensibly in front of others but make up for it in private'. However none of the South-Asian participants acknowledged using diuretics or emetics after bingeing. The authors concluded that South-Asians were most likely to exhibit sub-clinical bulimic behaviour. There was no association between BITE and acculturation scores.

Thomas, James and Bachman (2002) assessed the prevalence of eating attitudes in 11-16 year olds using the EAT-26. The authors reported that South-Asians also had higher EAT-26 scores than other ethnic groups and that in a multiple linear regression, ethnicity was a significant and independent predictor of very high EAT-26 scores. Compared to Caucasian participants, South-Asians were more than twice as likely to have a very high EAT-26 score (greater than 20 and therefore at the clinical cut off level). Thomas et al. (2002) also found that South-Asians were significantly more likely to score above 10 (the lower end of severe EAT-26 scores) compared to Caucasians.

Although both studies reported greater disordered eating in British South-Asians, this was only statistically significant as a predictor of high EAT scores in the Thomas et al. (2002) study. For participants in the Bhurga and Bhui (2003) study, it was the endorsement of particular items that was significantly different in South-Asians compared to other ethnic

[7] Bulimic Investigation Test Edinburgh

groups, which suggests that potentially, pattern of eating or eating behaviours in South-Asians may differ. Limitations of the Bhugra and Bhui (2003) study included the random selection of participants invited to interview rather than high scorers and the collapsing across different South-Asian populations into the South-Asian category, potentially masking any variation in different South-Asian groups.

One study recruited South-Asians from the Indian subcontinent in their comparisons of ED symptoms in different ethnic groups: Rubin et al., (2008) examined the prevalence of ED symptoms in 278 female students in the USA, France, India and Tibet. The South-Asian girls were sampled from a school in New Delhi, India and had the highest SES status from the groups as measured by parents' level of education. The authors found no significant difference between EAT-26 scores in all countries, even after age, BMI and SES were controlled for, and concluded that no one group was at greater risk of developing an ED. Therefore girls from India were equally as likely as Westernized counterparts to exhibit eating pathology. Whilst high SES is typically linked to disordered eating, this was not the case with the Indian girls, which suggested that higher religiosity (found for Indian girls) may have served as a protective factor.

Finally, one study recruited South-Asian participants who were residing in Oman, attending an Indian school, and compared them to Omani, European and American Caucasian as well as other minority students for eating disorder symptoms. Kayano et al. (2008) assessed DT[8] and attitudes towards bodyweight and shape. The authors found that South-Asians had higher 'bulimia' and 'food preoccupation' compared to Europeans and a significantly higher oral control score compared to European and Omani students. For South-Asians, there was a

[8] Drive for Thinness

negative relationship between BMI and EAT scores. Thus as BMI increased, there was a decrease in abnormal eating attitudes and behaviours. However despite the higher dysfunctional eating attitudes, Europeans had significantly higher drive for thinness.

Overall, the findings suggest that when compared to Caucasians, South-Asians are at increased or equal risk for eating disordered symptoms. The Rubin et al. (2008) study reported that South-Asian did not differ from Caucasian peers in the endorsement of eating disorder symptoms and Kayano et al. (2008) reported greater disordered eating in South-Asian (and other minority groups) compared to Caucasians.

4.4. Prevalence of body dissatisfaction in South-Asians compared to other ethnic groups

Six studies compared the level of BD in South-Asians to other ethnic groups. Seven hundred and eighty seven participants of a South-Asian background were included in the studies, and ranged from 14-42 in age (see table 4 below for study details).

Table 4. Rates of body dissatisfaction in South-Asians compared to other ethnic groups

Study	Country	Population	Sample	Measures	Findings
Mellor et al (2009)	Malaysia	High school boys & girls in the state of Selangor, Malaysia	240 boys and 289 girls Malay - 45 boys and 58 girls Chinese – 157 boys 187 girls Indian – 38 boys and 44 girls	Body Dissatisfaction Scale (McCabe & Riccardelli, 2004) Body Change Strategies to Lose Weight and Body Change Strategies to Increase Muscle from the Body Change Questionnaire (McCabe et al. 2002) Sociocultural influences on Body Image and Body Change (McCabe Y Riccardelli, 2001)	Indian girls did not report greater BD than their male counterparts - unexpected high level of dissatisfaction reported by boys in all ethnic groups. Indian girls engaged more often in behaviours to lose weight. Indians reported greater pressure from adults, siblings, peers to lose weight -suggests there are ethnic differences in perceived pressure and engagement in behaviours to both lose weight and increase muscle and that the pressure appears to be coming from a range of sociocultural agents. For Indian girls: sociocultural factors did not significantly explain variance in BD. However BMI and perceived pressure from siblings to lose weight predicted engagement in weight loss behaviours, and media pressure to increase muscle influenced frequency of engagement in muscle building behaviour. Adults and peers did not significantly predict attitudes and behaviours of Indian participants.
Swami, Airs & Chouhan, Leon & Towell (2009)	UK	University students in Greater London	131 Caucasian 122 South Asian (majority from India & Pakistan) 67 African Caribbean (West	Body Appreciation Scale Sociocultural Attitudes Towards Appearance Questionnaire-3	SA women had the lowest body appreciation score is consistent with the suggestion that they are increased risk for developing negative body image and

			Indian) 67 Hispanic (Iberian peninsula or Latin American)	Rosenberg Self Esteem Scale	eating disorders (Dolan et al, 1990). Asian women's scored higher on the SATAQ-3, implicating the influence of the media on Asian women's lower body satisfaction .
Bush et al (2001)	UK – Scotland	Community	63 South Asians born on Indian sub-continent (mean age 31) 56 British-born South Asians (mean age 26) 39 Italians born in Italy (mean age 34) 51 British born Italians (mean age 32) Control group of 50 non-Asian, non-Italian general population women (29 years)	Age, height, waist, hips & BMI 1. Evaluation of own weight or shape: attitude to current weight (very happy-very unhappy) Self assessment of current weight (underweight- very overweight) 2. Weight consciousness and attempts to modify weight: frequency of weighing, reported eating for reasons other than hunger, current attempts to change weight, past attempts to lose/gain weight, wished to lose/gain weight in past but unable to do so. 3. Influence of others' perceptions: whether mother dieted when respondent was teenager, pressure from others to change shape/size of body. 4. Evaluation of large silhouettes: photographic silhouettes of 6 BMIs 20-38 4. Participants asked which of 6 shapes was most/least likely: to get married, heart disease, have a long life, to be eating healthy food, to be eating good food to have healthy children, to get a good job, to be a healthy woman.	Migrant SA women – higher waist/hip ratio (indicating abdominal fat)- more likely be unhappy with current weight but were less likely to have tried to reduce it in the past and experienced external pressures. Migrant SA women (like Italians and general population) associated prestige determined by likelihood of marriage and the securing of a good job with the two thinnest silhouettes. However linked large body size with good/healthy food, womanhood, healthy and children but not with longevity. Evidence suggests British SA are moving towards the views of women in the general population of Glasgow – as SA women were not significantly different from the general population in past experience of pressure to change their body weight/size and perceived eating for reasons other than hunger.

Kennedy, Templeton, Gandhi & Gorzalka (2004)	North America	University students	Chinese – 890 (623 women 267 men) Indo-Asian - 130 (83 women 47 men) European descent – 451 (323 women 128 men) Final sample: 1471	Demographics – age, gender, country of birth, age of arrival in Canada (if applicable), first language, ethnic group Body image subscale of the Derogatis Sexual Functioning Inventory – it consists of 15 items, measured on a five point scale from strongly disagree to strongly agree	European descent group reported the most positive body image, followed by Indo-Asian and then Chinese, who reported the lowest satisfaction. 'I am too fat' item was endorsed by all three groups equally showed no main effect for ethnicity. Findings support previous research that Indo-Asians may suffer from more negative body image than their Caucasian counterparts (Mumford et al, 1991) Generally men tend to be more satisfied with their body across ethnicity.
Mahmud & Crittenden (2007)	Australia & Pakistan	College & University students	142 Upper (English Medium); students recruited from college in Islamabad 145 Middle (Urdu Medium); recruited from college in Rawal-Pindi 149 Caucasian Australian females; recruited from a uni in Australia	Eating disorder Inventory Body Shape Questionnaire Body Esteem Scale Figure Rating Scale	Australians showed lower body esteem and greater body dissatisfaction than either group, despite controlling for BMI. Pakistanis in English-medium college showed significantly lower body image dissatisfaction and fewer body shape concerns than Caucasians . However Pakistanis from English medium schools expressed greater concerns on BSQ and indicated less satisfaction with their weight and greater concerns about their lower body parts on BES. FRS also indicated the idealisation of thinness for Pakistanis. Australians as

					well as Pakistanis perceived their current figure to be larger than their ideal, opposite attractive and women attractive shape.
Gupta, Chaturvedi, Chandarana & Johnson (2001)	Canada & India	University students	65 Canadian women 89.2% White, 6.2% Black, 1.5% Oriental , 1.5% east Indian and 1.5% Other 47 Indian women 100% students were recruited from university in Bangalore, India and were all fluent in English.	Drive for thinness and body dissatisfaction subscales from EDI. A general measure of body dissatisfaction for all major areas	Canadian women scored higher BD scores than Indians. DT was not significantly different for two groups. When BMI was partialled out, both DT and BD were no longer significantly different between the two groups, suggesting that both groups were equally predisposed to experience a drive for thinness and dissatisfaction with the weight and shape of their abdomen, hips and thighs. Indian women's' body image issues are probably realistic and indicative of a more realistic concern that is related to higher BMI and normalizes once the confounding effect of BMI is partialled out Findings suggest some distinct body image constructs among Indians.

Three studies measured the prevalence of BD in South-Asian compared to other ethnicities, and also investigated whether acculturation/Westernization influenced rates of BD. Bush, Williams, Lean and Anderson (2001) assessed whether exposure to Western body ideals affected BD by comparing migrant South-Asian to British born Asians (to migrant and British-Italians and the general population) on measures related to perception of weight and shape. Bush et al. (2001) found that migrant South-Asian women had significantly larger waist/hip ratio than Italians and the general population, and expressed more dissatisfaction with their weight, but had done less than migrant Italians to reduce it. All groups rated the two thinnest figures as most prestigious, with increased likelihood of getting married and securing a good job. However, migrant and British South-Asians differed from Italians, and the general population, in their views of larger silhouettes (BMI above 28) as more likely to eat good food, give birth to healthy children and be healthy. Notably, significantly less British born South-Asians endorsed the larger silhouette figures in a positive way compared to migrant South-Asians, however they still did so more than the general population.

Mahmud and Crittenden (2007) assessed whether exposure to Western culture affected BD in two groups of Pakistani females, one from an English-Medium college and the other from an Urdu-Medium college, to Caucasian females in Australia. Caucasian females had significantly higher BD scores than either Pakistani group, who did not differ from each other. Regarding body shape concerns, all three groups differed from one another. Caucasians scored highest followed by Pakistani females from the English-Medium college and then Pakistanis from an Urdu Medium college. Overall Pakistanis showed less BD and greater body esteem than Caucasians, however Pakistanis from the English-Medium college exhibited significantly more body shape concerns than their Urdu-Medium counterparts. All groups however rated their ideal figure as slimmer than their current figure. The authors

concluded that factors protecting Pakistanis against BD did not appear to be a preference for a fuller figure.

Gupta, Chaturvedi, Chandarana and Johnson (2001) assessed the prevalence of BD in Indian and Canadian University students. As well as administering standardized measures, participants were required to rate each body area according to how overweight they felt each area was. Although BD and DT scores were higher in Canadian women, this difference was no longer significant once BMI was controlled for and suggested that both Indian and Canadian women were likely to experience DT and BD.

From the factor analysis, Gupta et al. (2001) concluded that whilst Canadian women tended to overestimate the weight of 'factor two' body regions (back, abdomen, groin, hips, thighs and legs) and wanted to lose weight regardless of BMI, this was not the case for Indian women. The authors suggested that BD for these body regions in Indian women was not necessarily a distorted perception of their body, but perhaps reflective of realistic concerns related to higher BMI. The authors also noted how a unique factor for Indian women (the face, neck, shoulder and chest areas) significantly correlated with DT and BMI in Indian women, but became insignificant when BMI was partialled out. Gupta et al., (2001) speculated that for Indian women, concern about the upper torso may be a reason for excessive dieting.

Two studies looked at levels of satisfaction with bodies and the influence of either acculturation or exposure to Western ideals. Kennedy, Templeton, Gandhi and Gorzalka (2004), compared the body image profiles of Chinese, South-Asian and Europeans using the Body Image subscale of the Derogatis Sexual Functioning Inventory (Derogatis, 1978). The authors found that South-Asians reported less body image satisfaction than European

counterparts. Also there was no significant difference for the endorsement of the item 'I am too fat' between the three groups – all three groups were equally as likely to claim it. Kennedy et al. (2004) found no relationship for South-Asian participants between length of stay in the country and BD. However the authors acknowledged that 84% of the participants had been born in North America.

Swami, Airs, Chouhan, Leon and Towell (2009) compared positive body image in South-Asian, Caucasian, African and Hispanic undergraduates. Results showed that South-Asians had the lowest body esteem of the groups and also that South-Asians reported higher levels of internalisation of messages from the media compared to Afro-Caribbean and Hispanic women.

One study focused specifically on the influence of sociocultural variables on BD in South-Asians. Mellor et al. (2009) investigated body change behaviours amongst Malaysian, Chinese Malay and Indian Malay school pupils. Results showed that Indian and Malay students reported significantly more strategies to lose weight than Chinese counterparts, despite Indians being similar to Chinese participants in BMI. Regarding pressures to lose weight, Indians reported significantly greater pressures from older siblings compared to Chinese participants. There were no significant predictor sociocultural variables for BD in Indian participants. Regarding weight loss for Indian participants, only BMI and perceived pressure from older siblings and cousins emerged as significant predictor variables. The authors speculated that family dynamics of Indian participants may be worthy of future consideration, as adults and peers did not emerge as significant predictors of attitudes and behaviours.

Given the variation in measurement of BD and sample characteristics, comparisons across the studies must be made tentatively, however it would appear that exposure to Western ideals in South-Asian populations impacts on BD. The two studies that measured body image constructs in Pakistani and migrant Asian populations reported lower levels of BD/body image concerns than Western peers, which suggests that less exposure to Western body image ideals may protect against poor body image. This was further evidenced in that 84% of Kennedy et al. (2004) South-Asian sample had been born in North America and they exhibited the lowest levels of body image satisfaction. Also Swami et al. (2009) found that British South-Asians reported the lowest levels of positive body image in comparison to other minority groups. However standardized measures of acculturation were not used in any of these studies. Rather Bush et al. (2001) compared across migrant and British born South-Asians and Italians, and Kennedy et al. (2004) used number of years as resident in North America as their measure. In addition, both studies did not measure SES, a known variable to affect BD, therefore lower BD may have been the result of SES. Furthermore, Kennedy et al. (2004) did not measure BMI in participants, a variable known to affect body image in South-Asians (Gupta et al, 2001).

Regarding the influence of sociocultural variables on BD, Mellor et al. (2009) did not report any significant sociocultural predictor variables for BD in Indian participants in their sample. This is contrary to the finding that South-Asians reported significantly higher levels of sociocultural influences on body image in the Swami et al. (2009) study. Both studies however used different measures of sociocultural influence, and given that the samples were recruited from the UK and Malaysia, information from the media is likely to have varied.

4.5. Influential factors of body dissatisfaction in South-Asians

Three studies investigated the relationship of 'teasing' and BD in South-Asians. A total of 385 female South-Asians residing in the US and India participated in the studies (see Table 5. below for details).

Table 5. Influential factors for body dissatisfaction for South-Asians

Study	Country	Population	Sample	Measure	Findings
Iyer & Haslam (2003)	USA	University students	122 American undergraduate women of South Asian descent (born in, or with at least one parent form the subcontinent).	BDI Body Shape Questionnaire EAT-26 Multigroup Measure of Ethnic Identity (MMEI) Racial Teasing Scale Rosenberg Self Esteem Inventory Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)	The role of racial teasing in disturbed eating behaviour and body image is supported. Racial teasing was associated with both BDI and EAT-26, with an effect size described as medium. These effects remained when distress, self esteem, SES and BMI were statistically controlled.
Shroff & Thompson (2004)	India	High school girls and University women	96 seventh grade girls from a private school in the city 93 female undergraduates from Bombay	BD & DT subscales from EDI Perception of Teasing Scale (POTS) Sociocultural Internalization of Appearance Questionnaire-Adolescents (Adults) the internalization subscale of the Sociocultural Attitudes Towards Appearance Questionnaire-3	Interpersonal teasing either mediated or partially mediated the relationship between BMI and body dissatisfaction. It appears that teasing is more influential in predicting drive for thinness for the adolescent sample than adults. Interpersonal and media influences may also relate to body image and eating concerns in women and girls in India.

Reddy & Crowther (2007)	USA	University students and adults affiliated to South Asian organisations	74 South Asian women Sample was predominantly Asian Indian (83.8%), Pakistani (9.5%), nepalese (1.4%) and more than one Asian sub-group (5.4%). 69% born in US	EAT- 40 Body Esteem Scale Ideal-Body Internalization scale-Revised (IBRS) Physical Appearance Related Teasing Scale (PARTS) Measure of ethnic teasing – developed a 26-item scale, including adapting items from the PARTS and the Schedule of Racist events. Suinn-Lew Asian Self Identity Acculturation Scale (SL-ASIA) Cultural Values Conflict Scale (CVCS)	Teasing about weight, shape or general appearance contributes to BD but may also lead to maladaptive eating attitudes in South Asian women. Results suggest cultural conflict rather than acculturation per se, is more problematic as it leads to BD and maladaptive eating attitudes. Thin-ideal was not associated with BD or maladaptive eating attitudes, which suggests this construct may not be a risk factor for SA women.

Iyer and Haslam (2003) found racial teasing independently predicted BD and maladaptive eating in American South-Asian undergraduates, however, racial teasing was not correlated with ethnic identification and weakly correlated with acculturation. The authors concluded that racial teasing was a distinct factor in eating and body image disturbance, separate from acculturation and ethnic identity.

Reddy and Crowther (2007) assessed the relationship among teasing (ethnic, weight and shape and appearance teasing), the internalisation of the thin ideal and BD in South-Asian women. The authors found that lower body esteem was related to all three measures of teasing and maladaptive eating. Whilst ethnic teasing did not significantly predict body esteem beyond BMI and general weight/shape teasing, it was related to BD, and cultural conflict mediated the relationship between ethnic teasing and BD. Reddy and Crowther (2007) suggested that South-Asian women, in an effort to avoid teasing may reject their minority identity and adopt the majority values. Thin ideal internalization was not related to BD or disordered eating, and women who reported greater ethnic and appearance teasing were less likely to endorse the thin ideal. Reddy and Crowther (2007) concluded that the thin ideal may not be a relevant risk factor for maladaptive eating in SA women.

Shroff and Thompson (2004) explored the relationship between teasing, BMI, media internalization, BD and DT in students in India. Using structural equation modelling, the authors found slightly different results for each age group. For the adult participants, BD and internalisation of sociocultural variables predicted drive for thinness. In adolescents the role of teasing predicted DT, and teasing had a direct effect on BD which was not mediated by internalization of sociocultural variables. The authors concluded that these differences may exhibit the differing functions of teasing at various ages.

All three studies reported significant effects of teasing on eating behaviour and BD in South-Asians.

5. Discussion

The aim of the present review was to examine the evidence for eating disorders (ED) and body dissatisfaction (BD) in South-Asian populations. Sixteen studies were identified that met the inclusion criteria and 1,676 South-Asian participants were included, ranging in age from 11-40 years and were recruited from the European, Asian, American and Australian continents. The following section summarises the findings in relation to the review questions, as well as discusses limitations of the studies reviewed and makes recommendations for future research.

5.1 How strong is the evidence for eating disorders in South-Asian women?

Several previous reviews have focused on the evidence for ED in ethnic minorities. One review in particular, by Cummins et al. (2005) examined the evidence in Asian populations specifically. For South-Asians in their study, Cummins et al. (2005) commented on the finding that British South-Asians seemed to present with ED symptoms more so than Caucasian peers, however there were methodological flaws with many of the studies. Cummins et al. (2005) also found that the 'culture conflict' hypothesis was well supported: the idea that second generation British born South-Asians living in traditional families may experience conflict over lack of control and autonomy and manage this through restricting eating (McCourt & Waller, 1995), but again there were methodological limitations with the studies. Brown et al. (2009) found studies examining the evidence for ED in Asian populations reported low levels of diagnosed AN and BN, but equal to Caucasian levels of Binge Eating Disorder. The use of purging after meals and laxatives and diuretics in Asians was also less compared to Caucasians and other minorities. Asians in the Brown et al. study however referred to mostly Far Eastern (e.g. Chinese) individuals.

In the present review, three studies focused on diagnosed eating disorders in South-Asians, two of which explored the profile of symptoms in patients in mental health services. The only study in the present review to report prevalence rates (Suhail and U-Nisa, 2002) was conducted with a Pakistani sample restricted in terms of socio-economic representation. Studies that are conducted in other parts of Pakistan and indeed over the Indian subcontinent are needed. Furthermore, to the author's knowledge there was a paucity of studies assessing the prevalence of eating disorders using the two-stage method in South-Asians in the UK. This is surprising given the high prevalence rates that were estimated in British South-Asians (3.4%) for BN according to Mumford et al. (1991). It is difficult to comment how the evidence for diagnosed ED in South-Asians has developed since Cummins et al's. (2005) review as so few studies were carried out. However the prevalence for BN is higher than the estimated 1.42% in Asian populations as reported by Brown et al. (2009).

Although AN is considered to be rare in ethnic minorities (e.g Mumford et al., 1992; Lee, Chiu & Chen, 1989), clearly from the Tareen et al., (2005) study measuring the symptom profiles of AN in adolescents, AN does occur in South-Asians. In adolescents with AN, there appears to be a lack of fat phobia, an important diagnostic criteria. However, at the time of writing, there had been no studies found to investigate symptom profiles of South-Asian adults with AN – do they also present with absence of fat phobia? Furthermore, research to date does not address how symptom profiles progress over time and what factors are important in the development of eating disorders in South-Asians? Longitudinal research measuring these factors in South-Asian girls into adulthood would allow for monitoring of changes. Also, although it is useful to measure which features are endorsed by South-Asians with eating disorders, this limits understanding about how the eating disorder manifests itself

and why it is present (e.g if fat phobia is absent, what else drives not eating?). Qualitative investigations would help to address this gap in the literature. Katzman, Herman, van Hoeken and Hoek (2004) utilised a mixed methods design to explore AN in Curaçao women. They found that these women had distanced themselves from the majority Black community; were trying to conform to the Caucasian elite group; and considered themselves to be different from the norm. Such studies in South-Asians with ED are necessary to understand how the ED functions.

Regarding the presence of eating disorder symptoms in South-Asians compared to other ethnicities, the evidence reviewed suggests that South-Asians are more or equally at risk to Caucasian participants, which was similar to the outcome in Cummins et al. (2005) paper. However, there was heavy reliance on self report measures for ED symptoms. In addition few studies reviewed reported how scores clustered together on scales used to measure maladaptive eating or BD. Cummins et al., (2005) discussed how that due to lack of factor analytic studies there is ambiguity about how a measurement tool may be operating in certain groups. The individual item analysis by Bhugra and Bhui (2003) revealed ethnic differences in endorsement of certain items on the BITE. Therefore it would be useful for future studies to investigate the way certain symptoms are reported or cluster together in different ethnicities.

Bhugra and Bhui's (2002) findings raise a second issue: Most South-Asian participants are from a Muslim or Hindu religious faith, where keeping fasts are not uncommon. Therefore fasting may not be linked to typical disordered eating, but rather a culturally appropriate behaviour. Thus unawareness of the motivation behind a behaviour may lead to erroneously

high scores. Consequently it is important that the properties of a measure are explored in the sample to which it is applied.

5.2 Effects of Westernization on body dissatisfaction

From the studies reviewed presently, it would appear that South-Asians with more Western exposure express greater BD. This is not something that was explicitly measured in the Cummins et al. study (2005), so it is difficult to know how this finding differs. However Brown et al. (2009) reported that there was no link between acculturation and eating disorder symptoms (including BD) in Asian populations. It is important to note that the Asian population in Brown et al.'s (2009) review referred to those originating from Far East Asia (e.g. Chinese and Japanese). Despite the three studies that reported greater BD for more Westernised South- Asians, Westernization was assumed by location (either at an English speaking academic institution in the Indian subcontinent), or by migration status. This definition is problematic as, for example, British born South-Asians in the Bush et al. (2001) study were considered to be representative of Westernized South-Asians, however it is possible to live a lifetime in a Western country and still be unacculturated (Berry, 2005). Thus further exploration of ideals/values held and how these interact with body image are needed in order to support this hypothesis. Qualitative studies in ethnic minority groups can help to achieve this. Anderson-Fye (2004) explored body image concerns in girls from Belize, interviewing them over a 5-year period. Results showed that for these girls, size of the body was not as important as the proportions.

Also the idea that South-Asians are protected against Western ideals needs further investigation. In particular, there is a notable absence of measurement of religious affiliation which could potentially be a relevant protective factor. Mahmud and Crittenden (2007)

alluded to this in their finding that Pakistani girls exhibited less BD. As most Pakistanis are Muslim, and Islam promotes modesty and disapproves of vanity, there may be less pressure for Muslim women to conform to thin-ideals promoted in the media (Ahmed, 1992). Research by Mussap (2009) found that Muslim women's strength of faith was inversely related to BD.

All future studies should aim to provide more detailed description of South-Asian participants, including specifying from where they originate, religion ascribed to and cultural beliefs in order to begin to understand the influence of sociocultural variables on ED and BD.

5.3 How does body dissatisfaction relate to eating pathology?

The relevance of BD in eating disorders in South-Asians is difficult to determine. This is an issue that was raised by Brown et al. (2009) in their review of ED in ethnic minorities generally. In the present review, Bush et al. (2001) found that dissatisfaction with weight did not correlate with dieting in South-Asians, whereas it did with Caucasians. Tareen et al. (2005) reported that fat phobia was absent in South-Asian anorexics and Reddy and Crowther (2007) reported that South-Asian women who were racially teased and expressed greater BD were less likely to internalise the thin-ideal. Future research should address what factors transition BD into dieting and potentially maladaptive eating in South-Asians.

5.4 General Limitations of the Reviewed Research

Several of the issues that are raised below are emphasised in previous review articles. Both Cummins et al. (2005) and Brown et al. (2009) discussed how reaching conclusions about the

evidence of ED in ethnic minorities is hampered by the methodological issues in the research. This is also problematic in the current study, and particular difficulties are highlighted below.

5.4.1 Appropriate measurement tools

The issue of utilising culturally appropriate tools to measure eating disorder symptoms has been explored (Brown et al, 2009). For instance three studies (Algeria et al., 2007; Nicdao et al., 2007; Taylor et al., 2007) assessed for the prevalence of eating disorders using the Composite International Diagnostic Interview (CIDI) a tool designed for cross cultural research by the World Health Organisation (Kessler & Ustun, 2004). The development of culturally sensitive tools for South-Asians should enable researchers to understand what factors are important in the development and maintenance of an ED.

5.4.2 Power of current literature review

Of the five studies that compared ED symptoms to other ethnic groups, a total of 638 participants from a South-Asian background were included in the current review, compared to 945 who were classified as Caucasian. Small sample size is problematic in obtaining enough power to achieve a significant result (Cummins et al., 2005). A meta-analytic study by Wildes, Emery and Simons (2001) reported a mean effect size of 0.41 for studies that found significant group differences in ED symptoms in ethnic groups. Cummins et al. (2005) discussed that to achieve a power level of .80($\alpha = 0.5$) at least 193 participants in each group would be required to produce significant group differences, and potentially more for unequal groups. In the six studies that investigated ED symptoms, only one study achieved this, however of the 287 participants, half were recruited from different regions of Pakistan

(Mahmud & Crittenden, 2007). Future studies attempting to measure the prevalence of ED or its symptoms should ensure that sample sizes are large enough to detect differences.

5.4.3 Sample representation

Almost all of the studies for the current review recruited either school or university students, which limits generalisability of findings and does not elucidate the potential prevalence of ED or BD in the adult South-Asian population. Furthermore studies that recruited South-Asian populations from the Indian subcontinent universities would most likely be selecting participants from the highest socio-economic status (SES). Studies have demonstrated the link between SES and eating disorder symptoms in ethnic minorities (Polivy & Herman, 2002). Therefore SES, when it is not controlled for, can potentially be a confounding variable in studies that report high prevalence of eating disorder symptoms in ethnic minorities. Future research exploring the prevalence of both ED and BD in different SES non-suburban participants from the Indian subcontinent is needed.

5.5 What treatment implications does this have for mental health services?

A recent literature review by Brown et al. (2009) discussed how mental health (MH) services for eating disorder sufferers were underutilised by ethnic minority groups. To account for this, the authors speculated that MH professionals may hold beliefs that ethnic minorities are protected against Western beauty ideals and are therefore unlikely to be affected by ED. However, there were clear cases of ED in the present review, both in the UK and on the Indian subcontinent. Prevalence rates in the UK for South-Asians were lacking and, to the author's knowledge, there were few studies in the past 10 years that attempted to measure this. Although the question of precisely how vulnerable South-Asians are to ED is not clearly

answered from the present review, there may be potentially undiagnosed and untreated cases of ED that are not reaching MH services. There is no published research, according to the author's knowledge examining the referral process for South-Asians with an ED. In addition, there also appears to be a lack of qualitative research examining meaning of ED symptoms within ethnic minority groups.

6. Summary

Similar to previous literature reviews in this area (Cummins et al. 2005) firm conclusions about the evidence of eating disorders in South-Asians are difficult to draw due to the disparate nature of the studies included in the present review. There are also methodological limitations to the existing literature, again consistent with previous reviews in the area (Cummins et al. 2005; Brown et al. 2009). However South-Asians report ED symptoms and BD at least to the same degree as other ethnic groups, in spite of often lower levels of presentation in clinical services, which is similar to previous review findings (Cummins et al. 2005; Brown et al. 2009). Level of Westernization appears to be an important factor in BD. This is contrary to what Brown et al. (2009) reported for Asian populations in their study where they found no evidence for Asian women who were more acculturated reporting greater ED symptoms, although the Asian population included in their study were Far Eastern Asian. However the relationship between body image and ED in South-Asians is not fully understood by the current literature.

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An exploration into the experience of an eating disorder and journey into treatment for British South-Asian women: What can we learn?

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1. Abstract

An exploration into the experience of an eating disorder and journey into treatment for British South-Asian women: What can we learn?

Shana Hoque

Introduction: Research has indicated the high (or at least equal) risk of disordered eating in British South-Asians compared to Caucasian peers. Despite these findings, British-South Asians are under-represented in eating disorder treatment services in the UK. Qualitative approaches are useful for exploring symptom recognition, how individuals act on these symptoms as well how treatment is sought.
Method: Six British South-Asian female eating disorder service users were interviewed about their experience of an eating disorder and journey into treatment. Interviews were analysed using Interpretative Phenomenological Analysis.
Results: Three overarching themes, with corresponding subthemes, were identified from the participants' accounts: the critical Asian society; parental experience: rejecting, tolerating and accepting; the role of self and voicing needs.
Conclusions: The participants described how the impact of the Asian community was widespread, impacting prior to the eating disorder and implicitly throughout the help seeking process. The parental response was an integral part of the journey into treatment for the current participants; most reported how their parents refused to acknowledge the eating disorder. Intervention from outside of the family appeared to be sought when physical health was compromised. However, for most of the participants, parents sought culturally familiar interventions such as consulting religious clergy. The experience of the eating disorder service was contrasted with the response most participants received from their families. Participants reported feeling listened to and validated by clinicians. Implications for treatment seeking in South-Asian women with eating difficulties are discussed. In particular, the need for exploration of how the experience of therapy may create further isolation of the South-Asian service user from her family. Future research is necessary to understand the family's experience of having a daughter in treatment, applicability of current models of treatment and drop out from therapy in South-Asian women.

2. Introduction

Numerous studies have investigated barriers to help seeking for eating disorder sufferers. The impetus for such research stems from findings that eating disorders are among the ten leading causes of disability among young women (Mathers, Vos, Stevenson & Begg, 2000) and that anorexia nervosa has the highest mortality rate of all mental health problems (Millar, Wardell, Vyvyan, Naji, Prescott & Eagles, 2005). There are three main types of eating disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM-IV-R*]; American Psychiatric Association, 2004): anorexia nerovosa (AN), bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS). Anorexia is characterised by low body weight, a fear of becoming fat and body image distortion. In bulimia, low weight is not necessarily present, but binging and purging as well as body image distortion are features. Eating disorders that do not meet the full criteria of either diagnosis are categorised as EDNOS. Eating disorders reportedly affect mostly women with an onset in adolescence (Striegel-Moore & Bulik, 2007). The need for effective recognition of eating difficulties and early intervention has been recognised in preventing what can otherwise be a protracted, chronic and life threatening condition (Striegel-Moore & Bulik, 2007).

2.1. Access to Eating Disorder Services

Generally treatment seeking for eating disorders has been evidenced to be problematic (Fairburn & Cooper, 1982). Meyer (2001) administered questionnaires on attitudes towards help seeking and a screening measure for eating disorders to 237 high school females. Results showed that 49% engaged in some sort of disordered eating, 16% enough to meet diagnostic criteria, yet only two had received counselling. Reasons endorsed by those in the clinical range to not seek treatment included not feeling as though they had a problem, feeling

as though the problem was not worrisome enough to seek treatment and not wanting others to know. Research endeavours are ongoing in trying to understand the factors involved in help seeking for eating disorders. For AN, one suggestion is the difficulty with recognition of the disorder due to the egosyntonic nature of the symptoms, such as drastic weight loss (Becker, Arrindell, Perlow, Fay & Striegel-Moore, 2010).

Two US studies have explored help-seeking for eating disorders using qualitative methodologies. Hepworth and Paxton (2007) explored help-seeking in 67 individuals with bulimic type behaviours. Regarding recognising the problem, participants reported that changes in their behaviour, comments about their appearance from others and psychological problems triggered identification of their eating difficulties. Barriers to help seeking included fear of stigma, low mental health literacy, shame, fear of change and cost of treatment. Finally, prompts to treatment seeking included increased symptom severity, psychological distress, interference with life roles, health problems and an increased desire to get better.

Becker et al. (2010) identified cultural and societal based barriers to eating disorder treatment in an ethnically diverse sample of participants. A range of ethnicities were represented in their study as research suggests that ethnic minorities are at greater risk of mental health problems not being recognised (Borowsky, 2000). Becker et al. (2010) noted how stigma, shame, social stereotypes, social norms and socio-economic distance formed culturally based barriers to care. Societal barriers included availability and affordability of health care. Although these themes emerged for both minority and non-minority groups, there were important differences in how they were experienced. For example, both minority and non-minority respondents in their study reported that social stereotypes affected accessing treatment. However a Caucasian participant reflected on how her help seeking was

facilitated by the social stereotype of mostly young Caucasian women being affected by eating disorders, whereas two African-American participants described how they perceived that their symptoms had been dismissed by clinicians because they did not fit the racially-based stereotype.

Research has been conducted in utilisation of eating disorder services by ethnic minorities. Cachelin, Rebeck, Viesel and Striegel-Moore (2001) found that African-American women were significantly less likely to receive treatment for their eating disorder in comparison to Caucasian peers. One factor demonstrated to affect referral to eating disorder services is low recognition at primary care level (Gordon, Brattole, Wingate & Joiner, 2006). Becker, Franko, Speck and Herzog (2003) found equally symptomatic Native Americans and Latinos were less likely to be questioned about eating behaviour by General Practitioners than Caucasians and speculated about whether use of racially-based stereotypes in clinicians prevented recognition of the disorder.

2.2. Eating disorders in ethnic minority groups

Research attempts to ascertain the prevalence of eating disorders in ethnic minorities to date have been problematic. Cummins, Simmons and Zane (2005) discussed how such endeavours have been hampered by changes in diagnostic criteria over time, and the application of diagnostic criteria to populations where it has not been standardized. Furthermore, large samples are required to detect eating disorder pathology (due to the low levels of eating disorders generally) and the method of accurately diagnosing eating disorders requires time and rigour (Cummins et al, 2005). Nevertheless, epidemiological studies suggest that the rates of clinical eating disorders in minority groups are lower than those reported in Caucasians (Brown, Cachelin & Dohm, 2009). Striegel-Moore et al. (2003)

reported prevalence rates of 1.5% in Caucasian women for AN and 2.3% for BN, yet in Black women, they found a prevalence of 0.0% for AN and 0.4% for BN. However, research examining prevalence of eating disorders in Asian populations, particularly British South-Asians suggests a similar level of risk of eating disorders to Caucasian populations (Cummins, et al., 2005).

2.3. Definition of South Asian

The term South-Asian represents a heterogenous group typically referring to those who originate from the Indian subcontinent. The actual definition of South-Asian varies depending on the study, with some studies defining it as those who descend from India, Pakistan and Bangladesh (e.g. Pandya & Herlihy, 2009) whereas others incorporate those groups plus Sri Lankans and East Africans (Marshall & Yazdani, 2000). The South-Asian categorization reflects a number of religions (predominantly Muslim or Hindu), spoken languages, ceremonies and traditions. However, these differences can be subsumed within the concept of Asian culture. Culture refers to the set of shared attitudes, values, goals and practices that characterize a group (Laungani, 2007). Reavey, Ahmed & Majumdar (2006) demonstrated how the variations as well as commonalities in South-Asian populations can be captured in qualitative research.

2.4. South-Asian populations: At risk of eating disorders?

Several studies have attempted to establish levels of either eating disorders or eating disorder symptoms in South-Asian populations in the UK. Mumford, Whitehouse and Platts (1991) ascertained prevalence for BN in a sample of 559 schoolgirls. They found significantly more South-Asians girls met *DSM-III* (APA, 1987) criteria for BN compared to Caucasians (3.4%

vs. 0.6%). Numerous other studies comparing prevalence of eating disorder symptoms in South-Asians to Caucasians reported similar findings (Ahmed, Waller & Verduyn, 1994; Dolan, Lacey & Evans, 1990; McCourt & Waller, 1995). The 'culture clash' theory has been proposed to explain the relatively high levels of disordered eating in South-Asian girls (McCourt & Waller, 1996). South Asian families are traditionally paternalistic and children within these families are subject to relatively overprotective parenting in comparison to Caucasian peers. Second generation South-Asian adolescents have the task of integrating their British and South Asian identities, which can be difficult in traditional families. Conflict over control is thought to develop and is subsequently managed in the South-Asian girl through restriction of eating. Mumford et al. (1991) found that those girls who lived in the most traditional families exhibited the highest scores for disordered eating in their study. Ahmad et al. (1994) compared Asian and Caucasian schoolgirls on eating behaviour and parental experiences. The authors found that South-Asians reported their parents to be more overprotective, and maternal overprotection was correlated with disordered eating. Furnham and Husain (1999), in a similar study, found no differences between disordered eating in Caucasian and South-Asian adolescents, but higher reported overprotection and conflict with parents in South-Asians. Furthermore, conflict with parent scores correlated with disordered eating. In summary, the evidence suggests that British South-Asian girls are at higher or equal risk of eating disorders as Caucasians and that this may be grounded in the culture of the South-Asian family more so than the factors that are salient in Caucasians such as 'drive for thinness' (Tareen, Hodes & Rangel, 2005).

Regarding South-Asians' presentation to eating disorder services, two UK studies have attempted to explore this issue. Ratan, Gandhi and Palmer (1998) examined the number of South-Asians presenting to an eating disorder service via a case note review over a 10 year

period. They found that the average rate of presentation for South-Asians with AN was 0.39 per 100,000 and for BN was 1.3 per 100,000. For the non-Asian population, the rate of presentation was 2.0 and 3.6 per 100,000 for AN and BN respectively. Therefore the average rate of presentation for South-Asians with AN was one fifth of that for the rest of the population, and one third with BN. Ratan et al. (1998) concluded that whilst eating disorders exist in the South-Asian population, the rate of presentation to eating disorder services was lower than that for the Caucasian population. Ratan et al. (1998) speculated that either eating disorders are uncommon amongst South-Asians or that there may be obstacles affecting help seeking.

More recently, a study by Abbas, Damani, Malik, Button, Aldrige and Palmer (2010) examined referrals of South-Asians to a UK Adult Eating Disorder Service over a 15 year period from 1991-2005. They reported that 75 South-Asians met the criteria for an eating disorder, six for AN (who were not included in further analyses), 26 for BN and 43 for EDNOS in that time period. The authors estimated that the number of South-Asian females (4.5%) in that age group presenting to the service was about a third of what would be expected according to the local population in that catchment area. When the authors compared the clinical symptoms between the patients, they found no significant differences on any of the variables, which suggested that the South-Asian women closely resembled their non-Asian counterparts in their symptom presentation.

One further study also found evidence of under-referral of South-Asians to eating disorder services. Waller et al. (2009) examined referrals to two UK eating disorder services in an ethnically diverse catchment area (including South-Asians). Of the 648 patients, 79 (12%) were ethnic minorities. Using the 2001 UK census data, Waller et al. (2009) found there was

a disproportionately large number of Caucasian patients compared to the percentage of Caucasian in the local population, whereas the number of patients from ethnic minorities was low. The authors speculated about non-identification of eating disorders in ethnic minorities in primary care services due to the evidence of high rates of disordered eating in certain minority populations, particularly South Asians (e.g. Mumford et al, 1991). There have been no published studies, to the present author's knowledge examining the barriers for South-Asian eating disorder sufferers, however there have been such endeavours for South-Asian mental health service users generally.

2.5. Mental Health Service Usage by South Asian Populations

Interest in mental health service use in South-Asian populations is growing, particularly given that they constitute 4% of the population in the UK (Bowl, 2007). Studies have reported that South-Asians do experience mental health difficulties (Nazroo, 1997; Anand & Cochrane, 2005), however South-Asian representation within mental health services remains low (Tiwari & Wang, 2008). Some research suggests that mental health services do not adequately meet the South Asian populations' needs (Bhui, Chandran & Sathyamoorthy, 2002; Bowl, 2007). Qualitative studies have been utilised to establish what their needs are and how mental health services can better meet them. Such studies have been conducted on South-Asians' views on family therapy (Pandya & Herlihy, 2009), mental health services generally (Greenwood, Hussain, Burns & Raphael, 2000; Bowl, 2007) and for South-Asian womens' use of mental health services specifically (Gilbert, Gilbert & Sanghera, 2004).

2.6. Rationale for the current study

At the time of writing, there has been a burgeoning of published qualitative research exploring the meaning, process and impact of eating disorders on individuals, families and clinicians. Several studies have explored service users' experiences of eating disorders using qualitative methodologies in order to inform therapeutic practice and provide an enriched understanding of recovery from eating disorders (Le Grange & Gelman, 1998). Reid, Burr, Williams and Hammersley (2008) examined eating disorder patients' views on their outpatient service experience. Key themes included: ambivalence about control and its role in treatment seeking; a practical and caring approach (in terms of managing the disorder); and reliance on treatment. Reid et al. (2008) discussed how important the sensitivity of professionals was in terms of not just focusing on weight but also addressing issues of control in order to break the cycle of control.

Despite the abundance of qualitative research focused on eating disorders, there has been relatively little published research examining the experience of ethnic minorities with eating disorders. It would seem there is increasing acknowledgment of the utility of qualitative studies in how they can enrich understanding of eating disorders, engagement with eating disorder sufferers and therapeutic practice. However there have been few undertakings with ethnic minorities, and questions remain about why they are under-represented in eating disorder services and whether the barriers to services are different. Furthermore, the importance of service users' views has been recognised in fulfilling the government agenda of 'Delivering Race Equality in Mental Health Care' (Department of Health, 2005).

Given the evidence of British South-Asians as an at risk group for eating disorders similar to the levels found in Caucasians (Mumford et al. 1991), and the suggestion of under-referral to

eating disorder services (Ratan et al., 1998; Abbas et al., 2010), a qualitative study into South-Asian eating disorder service users' journey into and experience of treatment is needed to address questions about the process, experience and impact of an eating disorder for South-Asians. In particular, it will explore what obstacles or facilitative processes were experienced. Also, it would enable understanding of how the eating disorder was recognised and understood within a cultural context. A qualitative design would also allow for subtle but perhaps important differences in the already existing concepts about access to treatment to emerge (Becker et al., 2010).

Understanding the journey into and experience of treatment in South-Asian eating disorder service users may illuminate potential barriers to accessing eating disorder services for South-Asians as well as other minority groups. It will also contribute to the understanding of eating disorders in a socio-cultural context. Finally, the importance of delivering culturally competent care has been documented in policy guidance (Department of Health, 2005). Such research can also contribute to defining the culture specific needs for South-Asians with eating disorders in order to aid cultural competence in healthcare professionals.

2.7. Aims

The aim of the current study was to explore the journey into an eating disorder service and experience of treatment for British South-Asian women.

In particular the following areas were addressed:

- What barriers to accessing eating disorder services were experienced?
- How have these women understood their eating disorder?
- How have they experienced the treatment they have received?
- What are the culturally specific implications for eating disorder services?

3. Methodology

3.1. Design

A qualitative approach was taken to explore British South-Asian women's journey into and experience of eating disorder services through the use of semi-structured interviews and Interpretative Phenomenological Analysis (IPA). IPA was chosen due to its emphasis on personal experience and suitability in meeting the research aims of producing an enriched account of journey into treatment for South-Asian women with eating disorders (see Appendix D for epistemology). Sample size varies in IPA from a single case to up to ten participants (Smith, Flowers & Larkin, 2010). The present author aimed to recruit six participants in order to represent a range of experiences but also be able to offer a thorough analysis.

3.2. Inclusion/Exclusion Criteria

Inclusion criteria were as follows:

- Participants had to be South-Asian, specifically Indian, Bangladeshi or Pakistani.

South-Asian was defined as those originating from the Indian subcontinent, specifically India, Pakistan and Bangladesh, which is consistent with the way South-Asian has been defined in previous research (e.g. Pandya & Herlihy, 2009; Reavey et al. 2006).

- Participants had to be female, aged 16 and above and English-speaking.

Given that most eating disorder sufferers tend to be young women, in order to achieve a homogenous sample (a principle of IPA) it was decided that only females would be recruited. Furthermore as the evidence suggests that the onset for eating disorders is usually between 15-25 years (Striegel-Moore & Bulik, 2007), most women eligible for recruitment were likely to be second generation and therefore English-speaking. However, due to the reliance on language in a qualitative approach and the possibility of expressions that might be lost in translation, non-English speaking participants were excluded.

- Participants had to have been identified by the clinical team as having a diagnosis of an eating disorder of the restrictive type: Anorexia Nervosa; Bulimia Nervosa; Eating Disorder Not Otherwise Specified (EDNOS).

It is possible that referral pathways and experience of treatment differ depending on the type of eating disorder specifically. However Fairburn and Harrison (2003) proposed a transdiagnostic model of eating disorders which suggests that most individuals fall into the EDNOS category, and some can oscillate between anorexia nervosa and bulimia nervosa diagnoses. The issue of a transdiagnostic approach has been explored further by Waller (2008), and the underpinnings of such an idea have been incorporated in other eating disorder qualitative research (Fox, Larkin & Leung, 2011).

- Participants had to be engaged with treatment, defined as input from an MDT (as per National Institute of Clinical Excellence guidance, 2004), from a mental health service, usually an eating disorder service.

- Participants had to be first time referrals to the service, i.e. they had not been re-referred, in order to achieve a relatively homogenous group of service users. Utilising a homogenous sample is an important facet of IPA research (Smith & Osborn, 2008).

Reasons for exclusion included being deemed too 'unwell' to participate by the lead clinician involved in their care.

3.3. Participants

Participants were six, British South Asian females ranging from 17-29 in age, with a diagnosed eating disorder currently in treatment from either an adult eating disorder service or Child and Adolescent Mental Health Services (CAMHS). Table 1 below gives a breakdown of ethnicity, diagnosis, age, service and length of time with service for each participant.

Table 1. Participant demographics

Participant Pseudonym	Ethnicity	Age	Religion	Diagnosis	Service	Length of time with service
Rukhsana	Memon (Kenyan)	17	Muslim	EDNOS	CAMHS	1 year
Adeela	Pakistani	17	Muslim	AN	CAMHS	4 years
Samina	Indian Gujarati	17	Muslim	EDNOS	CAMHS	1 year
Rani	Indian Gujarati	18	Hindu	BN	Adult Eating Disorder Service	6 months
Laila	Pakistani	29	Muslim	AN (binge/purge)	Adult Eating Disorder Service	1 year
Aisha	Memon (Malawi)	24	Muslim	BN	Adult Eating Disorder Service	6 months

In addition to the six participants described, two other participants were also interviewed. Due to the difficulties with recruitment, there was no fixed age limit, and length of time in treatment was recommended to be no more than two years as an ideal criteria. After obtaining eight participants, it was decided that six participants formed a more homogenous subset and two participants were excluded from data analysis. One participant had been a service user for 10 years, which was considerably longer than the other participants, and had used a number of services. Also the focus of the research was the help-seeking process and journey into treatment, which may not have been so readily recalled for this participant. The other participant was 42 years-old, and therefore comparatively older than the other

participants. She had also experienced a number of mental health problems over time, including depression and her mood was very low during the interview.

3.4. Location

Recruitment took place across eating disorder services located in Leicester, Birmingham Nottingham and Wolverhampton, and CAMHS in Leicester. All interviews were conducted in a private office in the buildings in which participants attended for their treatment of their eating disorder.

3.5. Ethical approval

Ethical approval for the study was granted by Derbyshire Research Ethics Committee for recruitment through the NHS and four Research and Development (R &D) Departments (Leicester, Birmingham, Nottingham & Wolverhampton). A minor amendment was made for participants to opt into the study with the use of Contact Information Sheet that key workers could give to the participant and then send directly to the researcher. The amendment was granted by Derbyshire Research Ethnics Committee and all relevant R&D departments (see Appendix A for details of ethical approval documents).

3.6. Materials

A semi-structured interview was devised based on discussion with clinicians in eating disorder services, the author's personal experience of culturally relevant issues and a review of the relevant literature (ethnic minorities and help seeking). Four key areas were included:

- Decisions to seek help – who was involved, how was the problem identified?
- Experience of receiving a diagnosis of an eating disorder
- Family involvement – reaction from family regarding their involvement with services
- Cultural issues – what made help seeking easier or more difficult and why might other South Asian women not access services for an eating disorder?

As the interview schedule was semi-structured, additional questions were asked based on the participants' responses (see Appendix E for interview schedule). All questions were open-ended and interviews were participant led in line with the phenomenological approach (Smith, Harre & Von Langehove, 1995).

3.7. Procedure

The current researcher attended team meetings at each site to discuss the objectives of the research and how to identify potential participants and distributed Clinician Information Sheets with details of the study and information about how to recruit (see Appendix F). Key workers in MDTs selected suitable individuals and provided them with the Participant Information Sheet (see Appendix F) which contained the aims of the research, as well as details about what the interview would be about. Participants were given a Contact Details Sheet (see Appendix F) to indicate whether they would like to be contacted by the researcher and to specify their preferred contact method, which they returned either in the post or gave to their key worker. The researcher then telephoned or emailed all participants who returned the form in order to address any queries and to arrange an interview at a date and time convenient to them. Participants were given a £10 gift voucher from Amazon as a thank you for their involvement.

Prior to commencing the interview, the researcher took informed consent (see Appendix F for Consent Form) and asked participants to complete a Demographic Information Sheet (see Appendix F). Interviews lasted between 50- 90 minutes and were recorded on a digital audio recorder. Participants were debriefed at the end of the interview by the researcher, which was not recorded. Upon completion of the interview the researcher made a journal entry commenting on the interview process and initial thoughts about what the participant discussed.

3.8. Data Analysis

The interviews were transcribed verbatim and analysed using IPA following the approach developed by Smith, Flower and Larkin (2009). Appendix G contains a step by step summary of the IPA analysis and an example of the analytic process. See Appendix H for information on quality issues that were considered in the analysis and writing up of the data.

3.9. Researcher's position

The interviews and data analysis were conducted by the principal researcher who was a 28-year old, Muslim, British-South Asian trainee clinical psychologist. The researcher was also on placement in an eating disorder service and therefore had clinical experience to draw upon. With respect to ethnicity, faith and clinical experience the principal researcher may have had a preconceived view of possible barriers to an eating disorder service. However, data triangulation (Golofshani, 2003; Smith, et al., 2009) was essential to address this concern. The principal researcher conducted some data analysis with two clinical psychologists of a Caucasian background, and participated in a trainee clinical psychologist

group with an interest in IPA where excerpts of interview data were shared, independently analysed and then perspectives were compared. Any disputes about the analysis were resolved through discussion.

4. Results

Three superordinate themes were identified from data analysis: 'the critical Asian society', 'parental experience: rejecting, tolerating and accepting' and 'the role of self and voicing needs'. These themes (summarised in table 1 with subordinate themes) were identified because of their importance and relatedness to the research aims.

Table 1. Superordinate and subordinate themes

Superordinate theme	Subordinate themes
The Critical Asian Society	Value of thinness
	Marriage & Marketability
	Fear of Outsider Intervention
	Exposing family: Shaming, failing and drawing attention
Parental Experience: Rejecting Tolerating and Accepting	Unacknowledged: denying the existence of the eating disorder
	Culturally familiar solutions
	Help sought in desperation
The Role of Self and Voicing Needs	Traumatic trigger
	Disconnection with culture: being different within the family and from the wider community
	The struggle to identify self vs the expectation to rely on self
	Treatment Services: acknowledgement & recognising needs

Below follows a detailed exploration of each superordinate theme with subordinate themes, using verbatim extracts taken from interviews for illustration[9].

4.1. The critical Asian society

4.1.1.Overview

This theme aims to reflect the importance of the Asian society on the women's experience of an eating disorder and of accessing treatment. For most of the women interviewed, the value of thinness was deemed to be both culturally acceptable and an appropriate attainment for Asian women. However, the pursuit of thinness and its transition into a diagnosable mental health problem impacted on participants' prospects for marriage. Indeed the eating disorder needed to be concealed in order for one participant to marry. All the participants reflected on the exposure of the family to the wider Asian community in both having and seeking treatment for an eating disorder. Therefore intervention outside the family and what was unfamiliar, though sometimes viewed as necessary by the parents of the participants, was feared.

4.1.2. Value of thinness

All but one of the participants spoke about the value of thinness in an Asian society, however the way in which participants expressed this varied. Some discussed the expectation of Asian men specifically and their demand for a slim partner. Samina described how her boyfriend and his criticism was a precursor to her eating disorder when asked about the triggers to her eating difficulties:

[9] For clarity (as emphasised by Smith (2011)) the results will encompass the participants' narrative and the interpretation will be made in the discussion.

> ‘He was a gym freak so he’d be like oh you’re kinda fat you know... that just snapped your confidence in half’ (Samina/21/637)[10]

Others discussed how commonplace it was for one to be on a diet or trying to achieve slimness as an Asian woman. This was also linked to worth or value as a person in some cases:

> ‘the community just generally likes thinner people... the Asian community’ (Aisha/21/301)

Three participants talked about specific incidents where they recalled being explicitly labelled as overweight and how unacceptable that was by significant others. Here Rukhsana discusses that experience:

> ‘Like one of my aunties is really/ actually all of them are really sort of straight forward and blunt with you and one of them was like oh you’ve put on a lot of weight and that’s when it was like oh my God people are actually noticing it’ (Rukhsana/15/ 396)

Although these events may have taken place some years ago, they seemed quite vivid in some participants’ minds and the associated feelings of shame and anger at the remarks were still present. Furthermore, it seemed culturally acceptable for Asian people to make such comments as described by Aisha:

[10] Indicates participant/page number/line number

‘the White community to an extent as well, but they don’t talk about it as much like with a White, with my white friends, I’d never go there and be like oh Maria, you’ve put on a bit of weight whereas with like Asian girls, they can be really mean sometimes.’ (Aisha/ 21/ 303)

4.1.3. Marriage and Marketability

Closely linked to the expectation to be thin was the importance of marriage either for these women themselves or by their parents. One participant talked about her hopes for getting married and being able to find a partner, and that serving as motivation to deal with her bulimia:

‘I really need to just sort my life out because I can’t get married like this you know, what are you going to say to your husband?’ (Aisha/16/232)

However, for another participant, it was the expectation of her parents that she was going to get married and how they were concerned that her eating disorder would prevent that. Samina discussed how her mother’s concern about her low weight was expressed in terms of marketability for getting married:

‘No she goes you’re losing so much weight...why you going so skinny for, no boy’s gonna marry you blah blah blah she’d make these stupid comments’ (Samina/26/800)

Samina later went on to discuss how her parents had tried to arrange a suitable husband when she was sent to India. She however had not been expecting that and perceived it as a way of her family trying to displace the responsibility of caring for her on to someone else. This was also the case for another participant, who talked about how her parents had already arranged her marriage to someone in the family when she was 8 years old. She described how their perceived frustrations at managing her psychological difficulties resulted in them taking her to Pakistan to be married. Whilst there, Laila described how her mother encouraged her to try and conceal her eating difficulties in front of the family and friends of her in-laws to be by not even attempting to eat:

> 'So she would say... erm oh people will apparently they'll know that you've got a problem with food, so just don't eat.' (Laila/36/557)

4.1.4. Exposing family: Shaming, failing and drawing attention

The theme of the family being 'exposed' because of the eating disorder was discussed in a number of ways by all participants. For some this was talked about in terms of the shame it caused or brought to the parents. Rukhsana discussed the importance of the family or parental reputation and how neither herself nor her mother conveyed the extent of her eating difficulties when she went to see the GP. Laila discussed how for her parents, she was not able to discuss her treatment for her eating difficulties because she was aware of the shame she perceived they felt:

> 'I think they... are a bit ashamed of you'
>
> (Laila/8/121)

Three participants talked about the exposure of the family through the process of therapy. In particular the process left some parents feeling as though they had failed in raising their children. Samina described how her mother stopped attending family therapy:

> 'She just said ah it's too much talking, and yeah she kept/ they kept, they weren't really contra/like saying bad stuff like how she was as a mother but she always felt like she'd failed as a mother cause I got anorexia, she always thought bad of herself, she always felt the doctors here were putting her down coz of that'
> (Samina/14/426)

4.1.5. Fear of outsider intervention

This theme, expressed by four participants, captured the resistance some participants experienced in seeking and accepting treatment for their eating disorder. One participant discussed how her family was reluctant for her to engage with services for fear of not only the label that may be attached to her, but also what the service may do to their daughter:

> '[parents][11] said that you know, don't [go] otherwise you'll get labelled as something you know... they'll do things to you like experiment on you but erm deep down I knew that I wasn't well.' (Laila/18/275)

For other participants, fear of outsider intervention related to the possibility of sectioning and the potential loss of their daughter:

[11] [ ] inserted by principal research

> ‘When I said okay I want to go the doctors then she actually was like, first she was like fine yeah we’ll go to sort of test it, to see if I wanted to go...but then she held it off for a little bit as well coz she said they’re gonna lock you up’
>
> (Rukhsana/16/445)

All participants talked about the anxiety they experienced in attending the first appointment at their eating disorder service, however for one participant there was serious wariness about even going to the GP about her eating difficulties as she was concerned about being detained:

> ‘I refused to go to the doctor’s coz then I thought I knew what they were going to do, I thought they were going to keep me there and stuff.’ (Adeela/7/195)

4.2. Parental experience: rejecting, tolerating and accepting

4.2.1. Overview

For all of the participants, the parental reaction was key when relating their experience of accessing services for their eating disorder. For some participants, their parents responded positively towards their daughter’s pursuit of treatment, however the participant was at times sceptical of their parents’ encouragement and some actively rejected their parents’ attempts to support them because they believed their parents were not genuine. The majority of the participants however reported a negative experience with the parental reaction, discussing how their eating disorder was not acknowledged by their parents. Some discussed how their parents valued more culturally familiar interventions over and above the mental health services. However, help from healthcare services was actually sought when the deterioration was physically alarming in their daughters, and her life was in potential jeopardy.

It is noteworthy that for all the current participants, only one independently sought help for her eating disorder. As three of the participants were recruited from CAMHS, it is not unusual that young adults will have their difficulties raised by their parents. However one of the three young women recognised that she was experiencing a problem, the other two did not. For the three adults, one had explicitly wanted to keep her eating disorder out of her parents' awareness, whereas the other two did not take any action until someone else raised it with them.

4.2.2. Unacknowledged: denying the existence of the eating disorder

All of the participants discussed how their eating disorder was unacknowledged by their parents at various stages of their journey into treatment. Some participants discussed how the label of a 'psychological difficulty with eating' was almost impossible for their parents to accept:

> 'Cos they have, they don't think that eating disorder exists. Even my husband erm he doesn't erm think erm, he thinks that eating disorders don't exist in this world. He thinks it's just yourself. You're doing it to yourself.' (Laila/9/133)

One participant related this to her parents being born in a non-Western country where education was not available. As a result of this lack of education it was not possible to accept the existence of an eating disorder generally, but also to someone in their family:

> ‘Because I think, coz they’re from back home and stuff, they’re not born here, I think the lack of knowledge and stuff, and coz they’re very very narrow minded in certain areas, it’s hard for them to open their minds to like eating disorders and just the whole idea of that happening to someone of their family members.’ (Samina/5/126)

Participants’ emotional reaction varied in response to parents reportedly turning a blind eye, with some participants expressing hurt and longing for their parents to understand, and others accepting that their parents could not grasp their eating disorder as a problem of the mind and therefore kept them separated from their treatment. Here Laila shares her realisation that waiting for her parents to be supportive was a reality that would never come:

> ‘I’ve just realised that erm that they’re not going to be supportive so if you just wait for them you’ll end up nowhere.’ (Laila/55/ 862)

As a consequence of the difficulty with parents accepting the label of an eating disorder, participants reported how parents attempted the use of force to encourage their daughters to eat:

> ‘Um within the culture again its sort of just like just eat you know, why aren’t you eating, it’s not a big deal it’s simple, put food in your mouth sort of/ like I remember when my dad first started to realise that food was a problem for me he literally like he’d put food on my plate and wouldn’t let me leave the table until I’d eaten it and that’s when I started to throw up after meals.’ (Rukhsana/14/378)

Participants also reported how their parents were aware of their restricting or purging behaviours at times, but seemingly ignored them:

> 'Erm well he heard me and he went Rani what you doing, and then I went nothing and then erm I came out, I was, I was sat with my mum and erm he made some remark he went oh you've, you, you've been throwing up in the bathroom haven't you? I turned around and I acted and I was like what? And he said nothing and he just walked off and after that there was nothing more said about it'. (Rani/27/410)

One participant had deliberately not told her family about her eating disorder in anticipation of them not being able to understand what she was experiencing, however they had recently found out about her service involvement by accidentally discovering a letter from the service just before the interview:

> 'Erm, do you mean why didn't I tell anyone? Because I'd never thought they'd understand like my mum even the other day she went I still, I'm still so confused about this.' (Rani/43/672)

4.2.3. Culturally familiar solutions

This theme was discussed by five of the participants. As most experienced their parents as rejecting of a psychological explanation, psychological intervention was not apparently prioritised by the families. One participant described how her mother held the belief that her anorexia nervosa was the result of a curse placed on her by a family member. Adeela

described how her mother became determined to find a cure for her daughter, but also her own curiosity about how those prayers may have helped to aid her recovery:

> 'yeah they did loads of prayers... mum used to make up her herbal remedy which was given to her by spiritualist people...that almost became all of her life, just like keeping me, almost like safe... I think at times it might have kept me safe because... I think myself, I would of maybe...even died if like I hadn't had, like I think at times I should have not been here if it wasn't for those spiritualist people.' (Adeela/19/578)

Several participants talked about how returning to their country of origin was considered by their parents to be the best place to determine what they were experiencing and to cure it.

> 'Sending someone to India's the answer to everything.' (Samina/33/1003)

This was met with resistance from the participants who reported feeling obliged to try it as a way of appeasing their parents:

> 'I knew that that wouldn't make me better...but I just did it for them, and I went all that way to Pakistan.' (Adeela/19/564)

4.2.4. Help sought in desperation.

Three participants discussed the acceptability of services by their families when they were physically deteriorating or beyond the capacities of the parents. Laila discussed how her family had moved her into a different home following her difficulties with eating as well as her struggle to cope with the loss of her nephew. Initially she discussed how her father was reluctant for her to see her psychiatric nurse, however as she deteriorated, this changed:

> 'Well...I did become quite ill and, and erm then I came back home erm cos then my dad did erm think that I should see her [nurse] but then I did.' (Laila/31/476)

Another participant discussed how her very serious physical deterioration led to her parents eventually finding the strength to leave their daughter in an inpatient unit, despite several admissions where they had previous bought her home, colluding with her wishes:

> 'And then the last straw came when I like... passed out at home and then, then my dad was like that's it I'm taking you to hospital and this, this time I really literally couldn't walk my weight went so low.' (Adeela/12/368)

For another participant, it was the level of despair witnessed in their daughter that led to help seeking, despite the parents expressed reluctance for fear of sectioning:

> 'I'd fast through the day and eat like half or a quarter of an apple and that was it throughout the whole day and um and I start/ I cried/ I started crying one day and I was like I literally just want to eat, I'd just/love to just go over there and grab like a Somosa or a Spring Roll and just eat it but I literally couldn't do it and that's when I

realised I can't keep going on like that, and so we came here I mean we came/ went to the GP.' (Rukhsana/18/491)

4.3. The role of self and voicing needs

4.3.1. Overview

The discovery of the individual self as separate to the family emerged as a theme in the journey and experience of treatment for all participants. In particular, all of the women had had a traumatic experience either prior to the onset of their eating difficulties or noticed a worsening of their eating difficulties following something traumatic. The therapy process was, for some participants, important in helping them to recognise, label and make sense of their eating difficulties, as well as begin to overcome them. For others, there was more ambivalence about whether their eating difficulties would be resolved, as the eating disorder had become more instrumental in managing their needs. All of the participants discussed their role within the family, with some talking about disconnection from their family, but acknowledging the difficulty with that and the yearning for closeness. Others discussed their duty and closeness to their family but separating out the eating disorder aspect as something that would be managed by healthcare professionals.

4.3.2. Traumatic trigger and the eating difficulties as a way of communication

This theme emerged for all of the participants in understanding the onset of their eating difficulties. For some there was a clear link between what they had experienced and how their eating was a way of managing that:

> ‘When I was a child erm my mum and dad, they sent me to India for a bit erm, and I was sexually assaulted there erm and then a few, a few weeks afterwards they came to India as well, my parents and erm I just stopped eating for some reason.’ (Rani/7/95)

Despite the nature of the experience which varied from bullying to sexual abuse to family separation, there was great reluctance to communicate that verbally to parents and instead, not eating became the emotional outlet:

> ‘Yeah I think that’s what like sort of like triggered it, coz I like used to go school and people used to tease me and at the beginning I sort of took it on the chin and then I think that it just became harder...then I wanted to go school less and do other things like I refused to eat and that’s how it sort of like came out and that because I never used to talk to my parents about it.’ (Adeela/4/96)

Reasons for not communicating with parents again varied, with some participants finding it difficult to express what they were feeling within themselves, and for others it was the fear of shame in conveying it. Although Rani had managed to overcome this and eventually tell her parents that she was sexually abused, Laila had not:

> ‘Yeah and my parents to this day, they don’t know that what happened to me because they don’t understand...even if... I tell them this is what happened they’ll say oh forget about it. You know, don’t say anything to anyone cos erm it’s something to be ashamed of.’ (Laila/25/383)

4.3.3. Disconnection with culture: being different within the family and from the wider community

This theme emerged for five of the six participants. For two participants there was a sense of always being different within their immediate family for unexplained reasons from an early age:

> 'typical parents sometimes, they don't let you go to school...but...my brothers and sisters, they went, so I just think I'm a bit different from them and that's why I'm not allowed and I used to think why, why to me.' (Laila/4/54)

For another two participants, their behaviour generally was considered to be rebellious and against cultural expectations held by their parents. Rukhsana described how her reluctance to follow cultural norms was not accepted by her parents:

> 'they think oh she doesn't really have that sort of cultural thing in her mind, she's a bit rebellious, so let's control her a bit more.' (Rukhsana/35/968)

For these participants, they described how their eating disorder was construed as a further attack on adhering to expectations:

> 'my mum noticed it, but being Asian and stuff, they don't really see it as a mental disorder or any kind of eating disorder, it's always like attention seeking behaviour.' (Samina/4/103)

Or, as in for one participant, as disrespect towards God:

> ‘my mum ever since she’s found out... she doesn’t understand that she really winds me up when she says this, but she’s always going on about how erm like food is God and its disrespectful and stuff and it’s a waste ...it is a widespread view of how...food is God and stuff like that.’ (Rani/57/885)

4.3.4 The struggle to identify self vs the expectation to rely on self

The struggle of having individual needs recognised and voiced was expressed by all of the participants. Some described how the self had been denied in their lives, and living life in accordance with culturally defined norms was supposed to be more important than self actualisation. Rukhsana described how she felt frustrated with this expectation:

> ‘there’s more to a person’s brain than just religion, following everyone else and education, there’s more than that.’ (Rukhsana/15/402)

Some participants talked about how the self was able to emerge through the therapy process and though it was difficult to talk about, sense was able to be made:

> ‘Sometimes we went through emotional periods of like/ of my life and stuff
> that I kinda hated talking about but I’m glad it happened’ (Samina/44/1382)

Conversely, two participants discussed how accepting intervention was perceived as unnecessary by their family and how their parents suggested they should possess the resources to manage their feelings, which Laila describes below:

‘they’ve said this to me so many times like you know this, look at you, you know, you should be grateful for what you’ve got instead of sleeping and feeling sorry for yourself and that’s what they think sometimes. I’m feeling sorry for myself that’s why I have er, I don’t eat but ... I never feel sorry for myself.’ (Laila/53/833)

4.3.5 Treatment Services: acknowledgement & recognising needs

The role of treatment services and more importantly, the response from healthcare professionals was spoken of favourably by all of the current participants. It is noteworthy that across all the interviews participants spoke less about the treatment experience. This may relate to the ambivalence some participants expressed in terms of recovery. In particular, despite receiving treatment for their eating disorder, the power of the symptoms and the relief and security having the eating disorder offered was also discussed by participants. Here Rani describes how much she values her bulimia nervosa despite being in treatment, and her recognition that other people will struggle to understand it:

‘It’s like something that I love and... no one else understands it’. (Rani/44/681)

However what appeared an important factor in the treatment experience was the acknowledgement of the eating disorder which was a welcome relief for many of the women, and in contrast to the reaction that they had received from their family members:

‘It did make sense um, honestly when I came here it was the best thing...they were really understanding... they actually made it feel like it was a problem, and it has to be

sorted out before it gets worse and that was such a big difference to my family, like my family were getting angry with me, and it's not a problem just eat'.
(Rukhsana/26/701)

Also, there was a sense of their individual needs being recognised and met by treatment services:

'she [therapist] just like listens to me and...erm she explains things to me which I didn't really understand...I think erm I made progress, even she thinks I'm doing well.' (Laila/46/716)

For one participant she described her eating disorder as life changing and how coming to therapy had affected drastically what she understood about herself and her experiences:

'Actually I didn't learn anything until I came here.' (Samina/11/331)

5. Discussion

The current study aimed to investigate the journey into and experience of treatment for British Asian women with eating disorders. Six women were interviewed from a range of eating disorder services, and transcripts were analysed according to IPA principles. Below is the interpretation of the three superordinate themes: 'the critical Asian society'; 'parental experience: rejecting, tolerating and accepting'; and 'the role of self and voicing needs' and their corresponding subordinate themes. Also, the themes' relatedness to wider research is discussed, as well as limitations and suggestions for future research.

5.1. The Critical Asian Society

The impact of the Asian society upon the current participants appeared to be multifaceted, affecting women in all stages of the process: before the eating disorder; as a precursor to the eating disorder; and before and beyond the help seeking process. All but one of the participants discussed the 'value of thinness' and the perceived pressures exerted on them to be slim which were not only those perceived from the external world, though some women did talk about the portrayal of celebrities in both Western and India media, but from their more immediate environments. In particular there was experience of being labelled by relatives as overweight, even in some cases where participants considered themselves, upon reflection, to be an average weight or shape. These experiences, in the way they were vehemently expressed in the interview, but also in the fact they were recalled sometimes many years after they had happened, seemed to carry strong undertones of shame and humiliation for the participants. McKinley (1999) discussed 'body shame' and how those who view their body negatively or against societal expectations may hold a representation of

themselves as internally bad. These experiences that the participants described, usually early on in adolescence, may have triggered body shame. The experience of critical comments about weight within the family is not unique to South-Asian women (e.g Haworth-Hoeppner, 2000), however there appeared to be a quality about the way these comments were publically made by family members (and the wider community) that suggested these women experienced a pressure to maintain a certain appearance. This may be further evidenced in theme of 'marriage and marketability' below.

In South-Asian culture, marriage is an important life event (Berthoud, 2005) and can be contemplated by parents for their children from age 16 onwards. In some cases, parents may want their children to complete their education, however by mid-20's, marriage is usually seriously considered by parents and the individual themselves (Dwyer, 2000). Previous research has reported the functionality of eating disorders as a way of managing (or avoiding) life transitions (Weaver, Wuest & Ciliska, 2005). One function of the eating disorder for some of these South-Asian participants may have been to avoid the expectation from their parents to marry by maintaining an overly thin body. From the descriptions of family life, it would seem that four of the participants were raised within a 'traditional' South-Asian family, where their parents may have held the expectation that their daughters would be married at a relatively young age in comparison to their Western peers. One participant talked about how, despite turning down the men suggested to her for marriage when she was in India, she showed compliance to her family's wishes by engaging in the process. Conversely the eating disorder may have prompted consideration of marriage by parents for their daughter, as was the case for two of the participants. Such a response to mental illness within South-Asian families is not unusual as discussed by Penny, Newton and Larkin (2009) in their exploration of South-Asian families' approaches to helping their family members

with psychosis. Penny et al. (2009) suggested that social and relational change was valued, and some South-Asian parents considered marriage for the young person with psychosis as a potential cure, and also as a way of securing someone to take care of their child. Participants in the current study however perceived the suggestion of marriage by their parents as a rejection of themselves and their needs.

For one participant there was awareness of the difficulty in securing a partner with her eating disorder. This then served as the impetus for seeking treatment. Therefore the pressure of marriage, though equally perceived by the participants who discussed it, functioned differently for the current participants.

The 'exposing family: shaming, failing and drawing attention' in some ways mirrored the 'value of thinness theme', in that the emotions participants described they experienced, they perceived their families to also experience. For the participants who sought treatment, there seemed to be an implication of drawing attention to and exposing the family, and in particular causing shame. Shame and stigma are concepts that are often quoted in the wider mental health treatment seeking literature as well as specifically to eating disorder treatment (Hepworth & Paxton, 2007). However, for those from a collective culture such as South-Asians, there is the wider exposure of the family to consider. Culturally, although South-Asians can experience stress, worry or sadness, these feelings should not be openly communicated outside of the family (Laungani, 2007). Therefore, help-seeking may indicate a failing to comply with cultural norms for some participants' parents.

Therapy for 'the family' in South-Asian culture may also generate shame, especially for first generation migrant South-Asians, where therapy in itself may be difficult because of the

requirement of emotion to be expressed in a public arena (Seegobin,1999). Some participants discussed how the requirement of parents to attend family therapy may have created feelings of being blamed as parents. This is not culturally unique, however the experience of blame may link closely to a sense of shame for these South-Asian parents in failing to raise their daughters (Reavey, Ahmed &Majumdar, 2006).

What was also striking from the current interviews was the 'fear of outsider intervention'. Two participants discussed how their parents were concerned about healthcare professionals sectioning them or experimenting on them. Whilst it is again not unique to Asian populations to worry about service intervention, perhaps it reflects the anxiety in South-Asian parents about the change that could potentially be brought about in their daughter by engaging with outside services. For example, one participant described how her father talked about her being 'experimented on', which could be an illustration of how she might be changed in some way. However, the fear of outsider intervention may create difficulty for the daughter in seeking and/or fully engaging with treatment, as respect and obeying parental wishes are central in South-Asian culture (Laungani, 2007).

5.2. Parental experience: rejecting, tolerating and accepting

The discussion about the parental response was a recurring theme in most of the current interviews and has received empirical support in other qualitative studies exploring eating disorders. In particular, meeting parental expectations is a commonly reported theme in literature examining eating disorder aetiology (Patching & Lawler, 2009). However there are perhaps two subtle variations with South-Asian eating disorder sufferers from the current study. The first is the high esteem with which parents are held in by South-Asian daughters'

and the importance of obeying and respecting them. Although some of the current participants spoke about their rebellion against these expectations, it seemed an ongoing conflict for some participants, between being rebellious and seeking parental approval.

The second difference was the acknowledgment of the eating disorder in the family. The majority of the current participants discussed how the eating disorder was not acknowledged, which was frustrating and saddening. Patching and Lawler (2009) described how 'conflict over cure' between parents and their daughter was a key theme in understanding women's experience of an eating disorder and recovery. However, participants in their study discussed their frustration with the perceived pressure to engage with treatment and recover by their parents. Participants in the present study discussed how parents were unwilling to accept the existence of an eating disorder, and how the idea of a mental disorder that prohibited eating was beyond their comprehension. Therefore, for those participants particularly in adult mental health services, there was complete denial about the eating disorder by their families. One participant described how she had reached acceptance about this in order to function within the family, however there seemed a sense of longing for the family support that she perceived other girls, who were Caucasian, received.

For those younger participants within Child and Adolescent Mental Health Services (CAMHS), perhaps there was more pressure for parents to engage with the service because of the expectation that parents would be involved in treatment. However, all but one of the participants discussed how their parents partially engaged with the treatment service before then completely avoiding it. There was only one participant who reported that her family were fully engaged with treatment, however this participant was extremely physically unwell and had had several hospital admissions, which would have been difficult to ignore in any family. This argument is supported by the 'help seeking in desperation' theme, where two

participants discussed how their parents were initially engaged with family therapy, but how as time passed and their weight increased, parents began to disengage. These accounts from the current participants seem to fit with the finding that psychological interventions are difficult to accept in minority or non-Western families and how physical explanations and interventions are sought and more readily accepted (Ma, 2008).

In consideration of the function of the eating disorder for some of the current participants, perhaps the denial of the eating disorder or minimisation of its severity by their parents reinforced the eating disorder for these participants who, with the exception of two, expressed ambivalence about their own recovery. Certainly for one participant, the way in which she described her eating disorder seemed to be her way of communicating to her family that she was unhappy with the restrictions placed on her in life. She described how she had continued to restrict and purge and her parents had failed to notice, despite the fact they had all been with the eating disorder service for a year.

From the current participants' accounts, although the eating disorder could not be acknowledged as a mental health problem, their loss of weight, changes in temperament and refusal to eat were responded to by their family at times, although this response seemed to be with what was culturally familiar to them. Several participants talked about how their parents consulted with religious clergy in trying to determine how their daughters could be helped. Research has shown that religious clergy in minority communities play an important role in terms of advising on spiritual, emotional and practical matters (Ali et al. 2005), and for the current participants, that appeared to be the case for their parents. Furthermore, there seemed to be a mixed response by participants to the cultural/religious suggestions. Participants initially discussed them in a disparaging way, however later expressed curiosity

about whether prayers may or may not have worked. Perhaps this reflected participants' own struggle with their identity within a Western culture, and a religious belief system that participants may have felt had been imposed on them, but then also finding some relatedness to it at times.

Another suggestion by parents, according to some of the current participants, was a return to their country of origin in the hope that religious clergy there might be able to heal them. This again is similar to the theme of social and relational change as discussed by Penny et al. (2009) for young people with psychosis, in that parents in particular endorsed religious clergy as being important in helping to heal their child. However, this appeared to be counterproductive for participants in the present study in that it seemed to leave them feeling more angry and rejecting of their South-Asian culture.

It could also be the case that participants' struggle with their family's lack of acceptance of the eating disorder service might have related to being second generation South-Asian. These participants would have been exposed to alternative models of parent-child relationships through growing up in Britain, especially those who had experienced inpatient care in specialist eating disorder units, where family therapy can be integral. Thus the participants may have held hopes or expectations that their parents might have supported them with their eating difficulties, which was rarely the case.

5.3. The role of self and voicing needs

The relationship between a traumatic incident and the occurrence of an eating disorder has been established (Smyth, Heron, Wonderlich, Crosby & Thompson, 2008), and was

corroborated by all the participants in the current study. However, for none of these participants were they verbally able to express what they had experienced, possibly because of the cultural expectation to overcome emotion rather than be consumed by it as discussed by some participants. Moreover, for the women who experienced sexual abuse, this may have been even more difficult to communicate for fear of shame (Reavey, Ahmed & Majumdar, 2006) as one participant expressed, and therefore the body became the source through which her difficulties were communicated.

The theme of disconnection between participants' and their South-Asian culture was identifiable for all current participants. The eating disorder itself seemed to create the ultimate disconnection, as it isolated them from their family, community and peers. However, some participants also discussed a sense of rebellion by having the eating disorder. Perhaps this gave participants a sense of authority over their parents that they felt they could achieve in no other way. It may also have reflected the independence that they were trying to seek in an interdependent environment (Markus & Kitayama, 1991). Markus and Kitayama (1991) discussed how those from a Western culture are likely to have an independent sense of self, whereas those from a non-Western culture are more likely to have an interdependent sense of self, where the self is linked to others. However, both senses of self can reside in one individual, and it seems plausible that for second generation South-Asians, these two states are likely to be experienced. However the families of the current participants seemed to continue to express an interdependent sense of self (with the expectation to keep their difficulties within the family, or accept marriage for example), potentially leaving these women feeling further isolated from their family and Asian community.

The theme of the struggle to identify the self (as opposed to self in relation to others) versus the expectation to rely on self may have also reflected the difficulties inherent of being bicultural. Research has documented the conflict that can be experienced by individuals who are bicultural and struggle to integrate their dual cultural identities (Stroink & Lalonde, 2009). The eating disorder, in the current study, seemed to be almost an expression of the self (or individual need), as it set the participant apart from her family, thus going against the collectivist ideology that permeates through South-Asian families (Suh, Diener, Oishi & Triandis, 1998). Complicating matters however, there was the reported expectation from parents for some participants to manage their own eating difficulties. However this seemed to relate to the parents' belief that the eating difficulties were not actually difficulties at all but rather an act of defiance by the participant against her parents. The struggle with balancing their South-Asian cultural identity, specifically meeting their parents' expectations and expressing their own needs seemed to leave some of the participants angry, confused and isolated.

The theme of 'treatment services: acknowledgment and recognising need' captured the way in which the response from services sharply contrasted with the response some participants were met with at home. The parental response was typically described as 'Asian': highly aware of the reaction of others and a tendency to ignore or deny the problem. The response from the treatment service however was attentive, empathic, inquisitive and supportive. The service was also described as naming and acknowledging the eating disorder, and giving voice to the participant, placing their experiences in context and validating them. It is interesting to speculate about why some participants attended treatment, given the ambivalence that was expressed in terms of recovery. However this may reinforce both the value of the listening and validating experience but also the power of the functionality of the

eating disorder. The way in which participants separated out what happened in therapy and what happened at home, and the necessary deliberation to keep the two apart, may have created a further divide between the bicultural identity and impaired integration between the two. Also for parents, they may have begun to perceive their daughters as more affiliated to the individualistic British culture as a consequence of having the eating disorder as well as engaging with treatment services.

It is interesting to note that one of the aims of the research was to capture the treatment experience, however this was discussed far less in the interviews. This suggests that other factors such as the familial experience and the perceived pressures of participants' community and wider society were more salient aspects in the eating disorder experience. Lack of discussion about the treatment experience may also have related to the power of the eating disorder and its utility to the current participants in managing their life circumstances. If this were the case, then the overcoming the eating disorder aspect to treatment would be less relevant to these participants.

5.4. Implications for eating disorder services – what can we learn?

There are a number of tentative implications that can be drawn from the current participants' accounts of their journey into treatment for an eating disorder. One potential barrier to accessing treatment may relate to the current finding that eating disorders are simply not recognised as a problem by either South-Asian parents or sufferers themselves. From the current participants interviewed, the eating disorder was unacknowledged, ignored or unaccepted within their families. It is important to stress there were variations in these

experiences, but they tended to relate to the severity of the physical health problem within the participant. For the others, it was a battle to achieve recognition by their families.

The current findings however, implicated the importance of parental support; even for those who struggled with their families and had reached acceptance about the lack of support, there was still regret and sadness about the situation. Lack of family support is not unique to South-Asians, but given the importance of family within South-Asian culture, eating disorder sufferers whose families are not supportive of their difficulties are likely to feel very isolated. Eating disorder services working with South-Asians or other ethnicities with a collectivist identity need to be aware of this dynamic in order to be able to better support their service-users.

The ambivalence regarding recovering from the eating disorder expressed by most of the current participants, may give rise to another treatment seeking implication. Hepworth & Paxton (2007) discussed the fear of change theme identified in their research of help seeking in patients with bulimia nervosa. For the current participants there seemed to be functional aspects of eating disorders that could be reinforcing, and fear of loss of these aspects may prevent treatment seeking. Some of the current participants described living in traditional South-Asian families, struggling to manage a bicultural identity and exert authority over life decisions. The eating disorder might serve as a way of exerting control or coping that becomes integral over time.

Regarding the experience of psycho-therapeutic interventions, family therapy, appeared to be counterproductive for the current participants in relation to eating disorder recovery. This does not mean to say that family therapy is inappropriate with South-Asians, as there is

evidence to suggest it can work well (Pandya & Herlihy, 2009). However it highlights the need for further research into the effectiveness of family therapy in South-Asian populations. At present, family therapy is recommended by NICE (2004) as part of eating disorder treatment in CAMHS. The present findings suggest that there needs to be consideration about the way family therapy is delivered for some South-Asian service-users presenting to CAMHS, particularly if it heightens blame for parents and leaves the service- user further isolated from her family.

The use of solutions common in South-Asian cultures to manage eating difficulties may also be a factor in why services may be potentially underutilised in South-Asians. The participants' reaction to their parents' suggestions varied from outrage to compliance for the sake of their family, to their own curiosity about what may help. Perhaps existing mental health services need to recognise that culturally familiar solutions are likely to be equally prioritized for some families with family members suffering from eating disorders and other mental health problems (Farooqi, 2006; see also Penny et al., 2009) and respond respectfully to this. Furthermore, this highlights the need for integration or improved links between eating disorder services (and other mental health services) and community resources (such as community centres or places of worship), to enable collaborative exploration around supporting the eating disorder sufferer. Basic mental health education for religious clergy as well as providing them with sign-posting to specialist services seems fundamental for South-Asian as well as other minority communities. Dissemination of psychological theories about eating disorders as disorders triggered by a variety of factors in order to reduce the risk of South-Asian parents feeling shamed and as though they may have failed as parents (Ma, 2008) is also necessary to enable families to support their daughter appropriately.

Finally, consideration should be paid to the therapy process itself with the individual and its propensity to further divide the South-Asian client from her family. The impact of an eating disorder on family life is widely acknowledged, and eating disorder sufferers often report feeling isolated (Fox, Larkin & Leung, 2011). However, perhaps there is something about the way in which the therapy process and the change it may effect in the individual requires further consideration and exploration. It is important to note that South-Asian participants mostly reported positive experiences with their therapist and felt listened to, understood and supported, in contrast to their experiences with their families. However the recommended models employed in treatment of eating disorders, Cognitive Behaviour Therapy and Interpersonal Therapy by NICE (http//:www.nice.org.uk) are centred around the self as an individual, and emphasise change and growth within the self. Perhaps the treatment outcome of such a change in South-Asian participants makes it then difficult for them to re-integrate with families who maintain an interdependent sense of self. Eating disorder services could consider this in their individual work with South-Asian clients either in a pre-therapy stage, or throughout the course of therapy. It would seem that involvement of South-Asian family members is a more complex process than is otherwise considered in Western families due to their interdependent sense of self.

5.5. Limitations of present research

The aim of the present research was to understand the experience of an eating disorder and journey into treatment for British Asian women. The secondary aim was to consider how these narratives might reveal potential barriers to eating disorder services for other British Asian women. An alternative inductive approach may have been to interview a non clinical South-Asian population to enquire about their beliefs about eating disorders and approaches

to dealing with it. Whilst this is a legitimate endeavour, it is however, important to capture the process for those South-Asians who have actually sought help for eating disorders to understand what barriers they faced and how they managed it. The understanding of the obstacles may then help to generate material for future research studies with South-Asian young women.

It must be acknowledged that as IPA is an idiographic approach, it is not possible to generalise these findings to all South-Asian women with eating disorders. However this was not the aim of the present research, rather it was to generate ideas of potentially relevant obstacles for South-Asian women to eating disorder services. Every individual's journey will be unique, however in accepting that a cultural group exists and that there are shared ideologies as defined by culture, there may be culture specific obstacles that can identified.

Related to this is the difficulty with the notion of culture and ethnicity. The present sample included a range of ethnicities from the Indian subcontinent – namely Indians and Pakistanis, who varied in religious beliefs, spoken languages and customary practices. All participants however were South-Asian and identified themselves as Asian rather than by their specific country of origin, and therefore formed a cultural group.

Also, due to the purposive sampling necessary to meet the research aims, there may have been sample bias, in that those who elected to be interviewed may have been the ones with negative experiences to share. In order to maximise the viability of the study, recruitment took place across several Midlands eating disorder services, and from at least one service there were several potential participants who were approached. It is unclear what these clients' reactions were to the research as the service contacted them by letter, however from

the services where all potential participants were approached in person by clinicians, none declined participation. Furthermore, within all accounts there were both negative and positive aspects about their experience of an eating disorder and the service with which they were engaged.

Finally it should be acknowledged that the principle researcher was a South-Asian female which may have impacted on the topics revealed and themes generated. However, data triangulation should have addressed this. Secondly, given the shame participants reported experiencing within their families, perhaps there was some reluctance to talk openly with a South-Asian principal researcher. However, there were a number of experiences that could have been deemed to be personal that were shared.

5.6. Future research

Future studies investigating South-Asian parents and families of eating disorder sufferers are needed. Such research, like the study undertaken by Penny et al. (2009), who interviewed South-Asian parents of clients from a psychosis service, may elucidate how parents feel about engaging with eating disorder services, how they experience family therapy and how other South-Asian parents can be encouraged to use services. They may also help to illuminate the applicability of family therapy to this group.

Regarding the perception of eating disorders in South-Asian communities, research is needed to understand the risk factors for eating disorders in young South-Asian women. There is already evidence to suggest that conflict with parents as a result of integrating two cultures increases risk of disordered eating (e.g. Mutajaba & Furnham, 2001), and the results from the

present research are in support of that hypothesis. All of the current participants reported feeling pressure to meet their parents' expectations and their struggle to exert themselves as independent people. Future qualitative studies investigating which aspects of the interaction with parents in particular are difficult, how eating or not eating impacts upon this and how women experience and manage their dual cultural identities are necessary to understand more about the parental conflict hypothesis in eating disorders as well as to identify protective factors for those who do not go on to develop eating disorders.

Finally the women who were interviewed were engaged with healthcare services. The quality of that engagement did vary from participant to participant, but on the whole, participants spoke positively about the experience. Future research is needed with those South-Asian women who both drop out of therapy or do not take up the offer of therapy after assessment. It may be that they share the concerns that the participants in the current study discussed, in which case healthcare professionals will be able to discuss and manage their fears in order to maximise service engagement. Related to this is the issue of effectiveness of therapy for South-Asian women. At present NICE guidance (2004) exists on evidence largely based on Caucasian women, and it is debatable as to how generalisable this is.

In summary, the present research highlights how South-Asian women in treatment for eating disorders may be unsupported by their families, and the difficulties this can create for them. There have been no qualitative studies to date looking at the experience of South-Asian eating disorder sufferers. However similar themes about the role of shame and exposure, and the difficulty of the familial experience and the empathic response from the treatment service were identified in existing studies examining the experience of an eating disorder (Patching & Lawler, 2009), though with qualitatively different meaning for the current participants.

With regards to barriers to treatment, the current participants who were already in treatment had overcome these. However there was discussion about the denial of the existence of eating disorders within the family of the current participants. Becker et al. (2003) in their study of access to eating disorder services for ethnic minorities found that clinician bias may have been an important factor. This could not be explored in the present study, but it is interesting to speculate how widespread the denial of eating disorders as affecting ethnic minority groups may be, and how in turn it could impact on help seeking. Furthermore, with such denial, treatment seeking may be difficult if it could lead to exposure of the family for the South-Asian individual. Becker et al. (2010) also discussed the impact of societal barriers on ethnically diverse service users with eating disorders. In particular they noted how culturally based barriers such as shame and stigma affected help seeking, and related themes were also identified in the current study. The experience of treatment received was not discussed in the aforementioned studies, however other qualitative investigations with eating disorder sufferers generally note the ambivalence participants can express when in treatment (Fox, et al. 2011) and how this relates to the utility of the eating disorder. Similar concepts were expressed in the present study, however the culturally specific implications were the dynamics within the South-Asian family and the sense of rebellion against cultural expectations. The themes identified in the current study are also in line with Brown et al's. (2009) findings in their review of eating disorders in ethnic minorities. For Asian populations, Brown et al. (2009) reported the complex interplay of several risk factors including cultural values and family environment in eating disorder pathology. Finally, the present findings implicate the need for consideration of treatment offered to South-Asian women, particularly family work, by eating disorder services in terms of appropriateness and utility.

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Critical Appraisal

Word Count: 3,371

1.1. Generating the research idea

Upon seeing an 'advert', from the clinical psychologist who eventually became my field supervisor, asking whether anyone would be interested in researching the South-Asian population within eating disorder settings, I was immediately interested. I thought it would be an interesting undertaking for three reasons. Prior to undertaking the research and my placement in an eating disorder service, I had no direct experience of eating disorders. Secondly, within almost 5 years of working in the NHS as both an assistant and trainee clinical psychologist I have had relatively little experience of working with South-Asians specifically. This highlighted the need for the research to me almost immediately as I thought about the potential generalisability of any findings to other mental health services. Thirdly, from my personal impression of the importance of physical appearance within South-Asian culture, my instinct was that there might be potential body image and eating difficulties for South-Asian women. These views were based on my own perceptions, as a South-Asian female who grew up in a predominantly South-Asian environment in the UK, but has a very much dual-cultural identity. I considered the South-Asian women I know, and how important being slim and having an attractive appearance seemed to be, to a greater extent than to my peers who were from other ethnicities. I also recalled the numerous conversations about marriage, potential partners and why maintaining that appearance (not just physical, but generally maintaining a positive image) was so important. I was conscious of the fact that there were numerous conflicts at times for South-Asian women of trying to achieve an appearance that encompassed a number of contradictory things: attractive, but modest; natural but not plain; and how these factors were affected by sometimes opposing religious and cultural practices. When my field supervisor discussed the research that had been conducted locally by the eating disorder service into the number of referrals of South-Asians over ten years I was curious about the topic, and thought that it would suit my goals of

wanting to produce research that have would have direct clinical utility and add to theoretical knowledge.

1.2. Planning the research

In the initial stages of the research I had made 'Freedom of Information' requests to several eating disorder services. Through requesting the number of South-Asian clients in each eating disorder service, I thought about the wealth of data that is routinely collected by services that is seemingly rarely used. For example, how many South Asian clients present to services? How many of these are English speaking or require an interpreter? What are the dropout rates in therapy for South-Asian clients? Also, how effective is the therapy for these clients? Existing routinely collected data could address all of these questions, and yet it does not seem to be collated and disseminated.

1.3. Recruitment

The recruitment process was challenging. I was aware that the South-Asian population in local eating disorder services was likely to be small, and therefore took a number of precautions in order to ensure I had a viable research project. Despite all my efforts in the planning stages, the reality of conducting research in the NHS was unavoidable. I was continually frustrated with services and individual clinicians, and felt that my efforts such as all the emails back and forth, were discarded or ignored. It was only with time and conversations with my supervisors that I realised the difficulties of research in the 'work place'. I was recruiting at a time when there were serious concerns about job security and services were being 'redesigned' due to new government agendas. I imagine that whatever the 'climate', research in the NHS can be problematic, however with clinicians so

preoccupied with their case load and meeting targets, I wondered whether anyone could invest in recruiting on my behalf? The clinician within me empathised wholly with their position, however I recognised that at some point most of the professionals that I was liaising with had experienced conducting research. I decided to change my approach and to assert myself in a way that was still respectful but made my own needs clear. For instance, rather than awaiting a response from a psychologist to recruit on my behalf, I requested to go back to a team meeting and appeal to clinicians myself. To my surprise most clinicians were empathic to my situation and active in assisting recruitment. Upon reflection, I wonder if I had taken that approach earlier whether recruitment would have happened sooner? Alternatively, perhaps it took that level of anxiety within me in order to prompt the clinicians I was in contact with to approach their clients.

2. Interviewing

2.1. Finding the balance

I was aware throughout the entire process of the stereotypical views of South-Asian people and was highly conscious of not wanting to play into them with the findings that I produced. However, there was also the issue of wanting to do justice to the accounts I heard from the participants. Looking back at the notes I had taken after the interviews, I realised that my empathy was often shared between the participant who had sat before me, the parents she discussed (that at times were described in a disparaging and dismissive way) and the potential other women who may have found themselves in such positions but never raised their issues with anyone outside of the family. I wondered about how my feelings paralleled with the experiences the women shared with me of being caught between different cultural demands.

I realised that myself as a clinician, researcher and South-Asian female were all activated at different points in the process.

The interviews themselves were a challenging experience, as I was not there in the capacity of my clinical role, but as a researcher. I wondered about how my ethnicity might affect the interviews; how able participants would feel to share their experiences with me? After all, I might be just as likely to judge them for the views they held, especially given that this was the experience they had with their family and South-Asian peers. I also thought about how the venue might have impacted on what participants talked about in relation to the eating disorder service. Might they have expressed less positive views about their therapists had we met in neutral territory? However, upon data analysis, I felt the participants were reasonably open and expressed a range of opinions. With regards to the experience of being with the participants, at times, I felt relatively close to some of the women I interviewed. The thought crossed my mind that these women could easily be friends of mine in a different situation. I suppose this reflected how the topics that were discussed resonated with me and my own life experiences. Growing up in a small close family with (at times) protective parents who instilled particular values were all aspects that were discussed that I identified with. The experiences the women discussed of feeling disconnected with their cultural identity led to me thinking about my own cultural identity. I could relate to their difficulties in maintaining the balance between my faith, culture and identity within my family. However, I wondered about the factors that affected that balance and why it was that I felt I had achieved it but they struggled to do so? What were the differences within our parents for example, or the way in which we ascribed to different cultural values? I thought about the cultural conflict hypothesis that has been proposed to account for disordered eating in South-Asian women

(McCourt & Waller, 1996), and how important understanding these issues will be in other research endeavours.

In thinking about the actual content of the material, I was very moved by some of what I heard. I felt anger at the way participants described how their parents responded to them and managed their difficulties. However, after leaving the interview and with time to process what I heard, I realised that there was not necessarily any deliberate cruelty in the parental response, but perhaps more likely fear, a different world view and lack of knowledge about alternative ways of responding. I thought about how difficult it might be for parents with a daughter who fought against the values they had tried to instil in her, and how they might have perceived therapy (or service intervention) as exacerbating this. I also thought about the position this left the participant in – the sense of guilt for disappointing her family, the anger at their refusal to support her and having no hope of them ever being able to. I wondered about family therapy and how it could be a suitable place in which these issues could be explored. However, how to get the family there? Perhaps the solution lies in taking the therapy to the family, or integrating therapeutic approaches into existing resources where these parents are more likely to access- such as community centres or at the local General Practitioner surgery.

I found I wanted to meet with the families of these women, to offer an alternative explanation. I especially found it challenging when some participants openly expressed a longing for their family to be supportive. Perhaps this related to my own sense of 'interdependence' within my family, and an appreciation of how difficult it would be to be separated from the family. Also, as a clinician I align myself to systemic theories, and recognise the importance of the wider 'system' with regards to why an individual experiences

difficulties, as well as to how those difficulties can then be managed. Such values within me probably created a stronger compulsion to want to intervene. I reminded myself, however, of how the dissemination of my findings could constitute my intervention, and how such an intervention would likely impact on a much wider audience.

3. The experience of IPA

IPA seemed an obvious choice of methodology for the research question, because of its groundings in the individual's experience (idiographic), the sense that can be made of that experience by the researcher (double hermeneutic) and also the way in which interpretation of those experiences might then be used to inform clinical practice and future research (in thinking about what might be potential barriers for South-Asian women in accessing eating disorder services). IPA is not prescriptive in its methodology, which allows for creativity and flexibility but also can provoke anxiety in the novice researcher at times. This is particularly so in the second order analysis, where interpretations can be made using a number of sources, the nuances in conversation, the said and to some extent unsaid (unconscious desires and wishes) and pre-existing literature or theory – all 'analytic strategies' (Larkin, Watts & Clifton, 2006) to make sense of a participant's narrative.

One particular struggle at the start of the research process was the issue of the interview questions. How could anything possibly 'emerge' when it was introduced by the researcher in the form of a question? I reminded myself of the philosophical underpinnings of the IPA, the idea that 'nothing is ever revealed as anything except when we encounter' (Larkin et al., 2006) and the interview is part of that encounter. Whilst I had reservations about using a semi-structured interview that was based on both pre-existing research and the intuitions of

clinicians in eating disorder settings, because I thought it would prohibit entering the lifeworld of the participant, what I learnt was that it did not. Rather it gave a focus, and the participant was still able to move relatively freely on to other topics or tangents within the interview, which is the benefit to a semi-structured approach.

3.1 Drawing out Themes

The process of selecting themes was challenging and intimidating, for the sheer number of possible themes that could have been drawn out and developed. In thinking about eating disorders more globally, I was tempted to analyse the themes that emerged around control for example, and to compare to the accounts from participants in the published literature (who would mostly be Caucasian). This would be a worthwhile endeavour for a research project in its own right, as the understanding of the function of symptoms would contribute to the existing knowledge about causal factors for eating disorders. However I needed to remind myself that the focus of the research was about the journey into treatment and to think about potential obstacles for other sufferers. Of course this gave me some liberty in that I was able to think about the function of an eating disorder itself and how that may be more powerful then wanting to receive treatment to eradicate it.

In identifying themes and thinking about what was specific or unique to South-Asian women, I found I had to remind myself of my critical realistic perspective. As I really focused on analysing, I found myself wanting to continually deconstruct. What did it mean to be South-Asian? What is actually culturally specific? There are many groups that would experience feeling restricted by the values instilled in childhood – those from a Catholic faith or Far Eastern (such as Chinese) origin for example. Also, for many people with mental health

problems generally, there can be a common experience of not being listened to and the therapeutic encounter offering the first experience of that. What I realised however was that at a human level there will always be shared experiences. However the nature of this experience will vary from person to person or group to group. Therefore, my research goal was not about trying to establish the differences between cultural groups with eating disorders per se, but rather the meaning surrounding behaviours/practices and customs for South-Asian women, and whether any adaptations from eating disorder services would be required to be able to better meet their needs? The findings that I have reported are not about what makes South-Asians different to other cultural groups, but about the way in which the same issue can be experienced in a qualitatively different way (such as parental expectation for example). Related to this are the clinical implications-the small adaptations that clinicians or mental health services can make in order to meet the needs of these service users. This also fits with the broader idea of cultural competence; it is not about therapists or services being different but adaptable to the needs of the client that is important.

3.2 The importance of self-reflexivity

I was aware of the potential bias in my research findings because of my South-Asian identity. I considered how the preconceptions I held about South-Asian women and culture may have influenced my findings, and therefore took precautions against this. I made use of the triangulation process by sharing the transcripts with supervisors, peers and examining the existing ideas in the literature. I also asked Asian and non-Asian peers within psychology and outside of it to observe how my ideas resonated with them. The journal I kept about my thoughts and feelings after each interview helped me to look out for overly empathic feelings that may have affected my interpretation. I also found 'debriefing' after the interviews with

my peers helpful. Through the process of sharing my thinking and hearing other people's views, I became aware of the truth to the statement that no one person is as involved in the data as the researcher. Thus a certain amount of confidence is required in presenting research findings, as well as acknowledgment of the subjectivity of the account.

3.3 Writing up

Presenting the results was problematic, particularly at the stage of trying to discuss the findings. The inter-relatedness of the themes and trying to separate them out for the purposes of clarity in reporting findings was challenging. Before writing up the findings, I thought about the way in which I had presented them and my rationale for doing so. An alternative way of doing it would have been to have one superordinate theme of South Asian culture and all the other themes feeding into to it. However, this overemphasized the cultural aspects, and would not have allowed the other experiences to have featured in equal right (such as the 'self' theme for example). I reminded myself that there is no one way of organising and interpreting the data, but rather a way that is owned by the researcher. Also, although I decided to separate out the analysis from the description of the themes for clarity, I believe that the entire process of identifying a theme is an interpretative exercise to some extent.

As I began to think about clinical implications I found myself wondering, for whom is the eating disorder a problem? If the functional aspects are so powerful, then where should our intervention efforts be placed? Should there be any intervention at all? In relation to 'culturally familiar solutions', I wondered about how many South-Asian women who may have had eating difficulties, and sought advice from either local, or religious healers, and for how many those interventions had actually worked? Perhaps to another clinician reading my

findings this sounds like a suggestion that eating disorder services are not the best provision for meeting South-Asian women with eating disorders needs. This is not the case at all, as clearly the women experienced the service they were receiving in a positive way. However, my overall sense was that there was ambivalence about recovery in most of the participants and I wondered why they were in treatment services. Perhaps there was something about the experience of being listened to and heard that was valuable, and recovery would mean the loss of that experience, which in turn jeopardised recovery. Or maybe the eating disorder enabled participants to have power over their parents, that again recovery would compromise. This raises a secondary issue about how therapeutic models function in South-Asian and other ethnic groups.

Although some participants discussed rebelling against their families, there was also the issue about not wanting to lose their families but to be accepted by them for who they were. Yet their families, from the participants' accounts, could not accept them. I found myself thinking about the balance of living between two cultures that could be experienced as oppositional. I also wondered about the issues clinicians might face in working with such clients. After all, to identify and embrace self-needs for South-Asian women may create conflict with her parents' wishes and desires for her, which may result in isolation from her family. I wondered about how this is dealt with in therapy. I also thought about when suggestions such as arranged marriages were made for bringing about change, how these were managed by both ethnically matched and ethnically different therapists? For me, it highlighted the importance of open conversations about these issues when working in multi-cultural environments.

4. Limitations of the Research

4.1. Participants' Feedback

Although it is not a requirement of IPA to actively seek out participants' feedback on findings, it is desirable. Of course, given that the IPA involves interpretation, participants may well disagree with the conclusions that have been drawn, but that is acceptable. I was disappointed that I did not have the time to feedback to participants and seek out their thoughts. I believe in a way it mirrors the therapy process, in that as a clinical psychologist, a formulation is constructed and offered back to the client. I would have liked to have had the time to share my thoughts and to have considered their responses. Not only would this have added to the validity of the research, but it would have created an open dialogue about my hypotheses.

5. Concluding thoughts

The research process and the interpretative aspect of IPA in particular has developed my epistemological position further and clarified to me that whilst I accept there is some objective reality, the way in which that reality is experienced will vary, and that each person's experience is informative. Prior to conducting the study, my research experience to date had largely been quantitative methods. However, I have always valued the 'idiographic' approach in the sense that I am curious about the individual experience. Although the experience of collecting, analysing and interpreting data has been arduous, anxiety provoking and uncertain at times, I think I have gained a number of skills that will be useful to me throughout my career as a psychologist and in any future research endeavours.

6. References

Larkin, M., Watts., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,* 102-120.

McCourt, J., & Waller, G. (1996). The influence of sociocultural factors on the eating psychopathology of Asian women in British society. *European Eating Disorders Review, 4*(2), 73-83.

Appendix A

Mandatory Appendices –
Letters to and from Ethical Committees
Research Chronology

Appendix B

Journal of Cross Cultural Psychology - Guidelines for Contributors

Appendix C

List of measures included in the studies in the literature review, with references

Appendix D

Epistemological Stance

Appendix E

Interview Schedule

Appendix F

Clinician Information Sheet
Participant Information Sheet
Participant Contact Details Sheet
Participant Consent form
Personal Information Sheet

Appendix G

Step by step coding and an example

Appendix H

Issues of quality in qualitative research