



# Therapists' Experiences of Working with Ethnic Minority Females with Eating Disorders: A Qualitative Study

Natalie Kanakam<sup>1</sup> 

Accepted: 25 April 2021 / Published online: 12 May 2021

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2021

**Abstract** Ethnic minority females are less likely to receive a diagnosis or treatment for an eating disorder (ED). This study captured the experiences of therapists who have worked with ethnic minority females to improve outcomes for this group. Twelve therapists in the United Kingdom, London were recruited for semi-structured interviews and thematic analysis was used to analyse the data. Shame was cited as a barrier to accessing help. This influenced therapeutic work such as not challenging shame or linking this to a negative interpretation of parents. Emotional and interpersonal factors were thought to be more common risk factors for the ED. The minimising of weight and shape concern and non-fat-phobic anorexia was thought to lead to a complex and delayed route to accessing ED services. Therapists felt restricted by service management who they felt required them to deliver a narrow range of therapies that had not necessarily demonstrated therapeutic outcomes in ethnic minority females. Nevertheless, therapists reported using curiosity to guide their cultural adaptations when feeling uncertain. When working with ethnic minority females, therapists face challenges from the therapeutic and diagnostic framework that services are aligned to. Creative solutions to address this include adapting the patient care pathway, referral guides, cultural reflective practice, and the use of cultural genograms and scripts in therapeutic work to address unmet needs.

**Keywords** Treatment · Diagnostics · Psychological therapies

---

✉ Natalie Kanakam  
Natalie.kanakam@gmail.com

<sup>1</sup> South London and Maudsley Trust, NHS, London, UK

## Introduction

Racial inequalities in society and healthcare are increasingly on the agenda, following issues highlighted by Covid-19 and the global Black Lives Matter movement (Khunti, Platt, Routen, and Abbasi 2020). The field of eating disorders (EDs) is not impervious to these inequalities. In 2014, the Government announced an additional £30 m in funding per year to support Specialist Eating Disorder Services (SEDS) across England (National Collaborating Centre for Mental Health 2015). The initiative was specifically intended to improve early access to treatment and provide national staff training to meet the needs of children and young people diagnosed with EDs. Nevertheless, a systematic review by Sinha and Warfa (2013) suggests that people in the United Kingdom (UK) from ethnic minority backgrounds are less likely to be diagnosed with an ED and, therefore, be referred to receive treatment.

Such inequalities must be addressed since EDs significantly impact a person's psychological and physical well-being (Fichter, Quadflieg, Crosby, and Koch 2017; Quadflieg and Fichter 2019). The UK lifetime prevalence of EDs is 15.3% (Micali et al. 2017). The prevalence rates in ethnic minority females in the UK are unknown. However, research in the United States (US) indicates that prevalence rates of EDs do not differ across ethnic groups ( $\chi^2 [3,1177] = 0.23, p = .97$ ) (Cheng, Perko, Fuller-Marashi, Gau, & Stice, 2019). The specific prevalence rates were as follows: 19.8% White, 19.9% Hispanic American, 20.7% African American, and 21.5% Asian American (Cheng et al. 2019).

Mortality rates are high with individuals mostly dying of causes related to the physical complications associated with EDs (Fichter and Quadflieg 2016). Moreover, long-term outcomes are poor, with only 30–38% of those with anorexia nervosa (AN) or bulimia nervosa (BN), respectively, recovering at 25-year or 11-year follow-up (Fichter et al. 2017; Quadflieg and Fichter 2019). A UK report found that the cost to individuals, families, and the economy was high (Price Waterhouse Coopers commissioned by BEAT 2015). Given these poor outcomes, people presenting with ED features, regardless of ethnicity, must be recognised and treated as soon as possible.

There is growing acknowledgement from commissioning groups that efforts should be made to reduce low utilisation of mental health services by ethnic minority patients (Joint Commissioning Panel for Mental Health 2014). A 2014 report expressly referred to the development of services that are personalised to the cultural and ethnic backgrounds of patients to improve outcomes (Joint Commissioning Panel for Mental Health 2014). The focus of ED research on the narrow demographic of help-seeking patients continues to marginalise ethnic minority patients (Sim 2019). Specifically, White females are shown to be over-represented in services, something which further cultivates the stereotype that EDs are more likely to occur in White affluent females (Sonnevile and Lipson 2018; Waller et al. 2009). This has hindered the development of theoretical and therapeutic models addressing the full spectrum of EDs (Becker 2007; Sim 2019). This could potentially impact engagement and treatment outcomes for ethnic minority patients,

although there is minimal published data in western settings addressing this (Sinha and Warfa 2013). However, it is known that at referral, therapists and GPs fail to consistently recognise uncommon presentations of EDs which fall outside the range of the ICD-10 criteria (Waller et al. 2009; World Health Organization 2019). Reduced recognition further alienates ethnic minority patients from seeking help (Becker, Hadley Arrindell, Perloe, Fay, and Striegel-Moore 2010).

Most empirical studies of ethnic minority patients with EDs in the UK have been conducted on patients' perspectives, with only two studies exploring the views of therapists (Chowbey, Salway, and Ismail 2012; Wales, Brewin, Raghavan, and Arcelus 2017). The perspective of therapists is therefore an under-researched area. This perspective is essential since therapists partly determine whether ethnic minority patients receive treatment, and the quality of the care they receive. Moreover, therapists represent the other half of the therapeutic alliance which is known to be a predictor of good patient outcomes (Flückiger, Del Re, Wampold, and Horvath 2018). Indeed, recent research has suggested that therapists who were externally rated as displaying racial and ethnic comfort when working with ethnic minority patients were better able to retain them in therapy and therefore not have premature termination of therapy (Owen et al. 2017).

Research into therapist's perspectives could highlight different ways to provide tailored, effective, and timely treatment of people with EDs regardless of ethnicity. Indeed, therapists hold a unique perspective that is influenced by their professional knowledge of SEDS, guidelines for treatment by NICE (2017), the ICD-11 diagnostic criteria and treatment models (World Health Organization 2019). Importantly, therapists hold insight into how ethnic minority patients they have worked with responded to and fitted within these therapy or diagnostic models and service guidelines. This includes insight into ethnic minority patients' presentation and treatment responses. Importantly, a therapist's perspective will give insight into how they perceive and work with cultural concepts in treatment, their cultural orientation, and cultural competency.

## Aims

This paper aimed to explore this area by focussing on the following research questions:

1. What are therapists' perspectives on how ethnic minority females diagnosed with EDs access SEDS?
2. What are the therapists' experiences of working with ethnic minority females diagnosed with EDs in SEDS?

## Method

### Design

This was a qualitative study that used semi-structured interviews to explore therapists' experiences of working with ethnic minority females with EDs. The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research guidelines (Tong, Sainsbury, and Craig 2007).

### Setting

Therapists were recruited from the researcher's professional network, via word of mouth, online social networks such as LinkedIn, or by direct approach. At the time of the interviews, all of the therapists worked in central London, which is an ethnically diverse and urban area. Although the exact proportion of ethnic minorities seen across London services is unknown, the ethnic demographic constitution of London is Asian 18.5%, Black 13.3%, and White British 44.9% (Race Disparity Unit 2018).

### Participants

Eleven clinical/counselling psychologists and one family therapist took part. Participants were recruited using snowballing and convenience sampling to obtain a representative sample of therapists in London. They were working across four different London-based community SEDS treating children and/or adults. Years of experience working with EDs ranged from 2.5 to 16 years.

All clinicians had experience of treating and providing therapy to ethnic minority females with EDs. For the purposes of this research, ethnic minority was defined as including South and East Asian, Asian British, Black, African, Caribbean, Black British, Mixed or Multiple ethnic groups, Arab or other non-White minority ethnic groups.

All participants were female except one male, reflecting the demography of clinicians working in EDs. Two-thirds of the participants were either White British or White Other ( $n = 8$ , 67%); the remaining were from ethnic minority backgrounds.

### Ethical Considerations

The study was registered with, and ethical approval was obtained from, the University Research Ethics Committee. The design of the study was informed by and complied with the British Psychological Society's Code of Human Research Ethics (British Psychological Society 2014). Before taking part, participants were provided with an information sheet that highlighted that the interview would enquire about sensitive topics such as addressing how therapeutic work is impacted by race. Moreover, it was emphasised that the aim was to improve services for ethnic

minority females with EDs. Participants were given time to consider the information sheet before giving written consent to take part. Consent was an ongoing process and verbally revisited at the start and the end of the interview audio recording, where participants' right to withdraw their data from the study was reiterated.

Participants have the right to expect that the information they provide will not be identifiable and will be treated as confidential. This required special consideration in this instance, since some of the participants were recruited from the researcher's own professional network. Given the interview questions surrounding the participants' opinions of their service management at their ED service, there could have been considerable concern to ensure their responses were confidential, resulting in social desirability bias. Therefore, efforts were made throughout the research process and interview to assure them that confidentiality and enhanced anonymity would be applied during transcription, and all information would be treated confidentially in accordance with the Data Protection Act 2018 (Thompson and Chambers 2011).

### **Data Collection**

The interviews took place by video call, telephone, or face to face. Interviews were conducted by NK, a clinical psychologist with extensive clinical and academic experience in EDs. Participants were asked questions which included the following:

- (1) What is your understanding or experience of how women from ethnic minority backgrounds access SEDS?
- (2) What are your thoughts on using NICE-recommended treatments when working with females from ethnic minority backgrounds?
- (3) Say an ethnic minority female had been referred to you and you were going to meet her for the first time, what sorts of things would you have in mind to prepare for the session and make sure it went well?
- (4) Have you ever adapted an ED therapeutic intervention to meet the needs of ethnic minority females?
- (5) What sorts of adaptations have you made to your therapeutic practice?
- (6) Have you seen any differences in how EDs are understood by ethnic minority females that you have worked with? If yes, in what way?

The interview asked follow-up questions linked to the therapists' responses and lasted between 45 and 75 min. Interviews were audio recorded, and the researcher made field notes during the interviews. The interviews were transcribed, and identifying information was removed. The transcriptions were not provided to the participants. It was deemed that data saturation was well obtained within the 12 interviews conducted. Since no new data could be obtained, further coding was not feasible, and therefore the study could be replicated (Guest, Bunce, and Johnson 2006).

## Self-reflexivity

The research process and outcomes were inevitably mediated by the author's identity and role as a researcher. Specifically, the researcher's own ethnic minority status and the fact that some participants had been recruited from their professional network may have impacted the analysis and interview process. This process is referred to as the reflexive process (Russell and Kelly 2002). This subjectivity replaces the idea of the value-free objective researcher, and the inter-subjectivity between participants and researchers is argued to enhance the research process (Wheatley 1992). Research outcomes are considered to be the result of co-authorship and active participation (Russell and Kelly 2002). This acknowledges that there are multiple realities, and is in line with the critical realist epistemology used in the study design and analysis (Bhaskar and Danermark 2006; Braun and Clarke 2013).

The study required reflection on clinical work, something which is considered standard practice for therapists. Nevertheless, the topics discussed in the interview may have triggered a sense of race-based stress and discomfort (DiAngelo 2011). Given the researcher's position as an ethnic minority person who has previously worked in SEDS, participants could have felt they were being tested on the quality of work they had provided. However, it is hoped that the participant information sheet and debrief at the end of the study clarified the position of the study, which was to elicit information to improve care for ethnic minority females diagnosed with EDs. Furthermore, the position of the study was reiterated during the interview to ensure that participants were kept at ease. The aim was to create an open and non-judgemental space during the interview.

## Analysis

The data were analysed using thematic analysis (TA) and critical realist epistemology (Bhaskar and Danermark 2006; Braun and Clarke 2013). Inductive TA was used to generate themes that were derived from the data as opposed to being derived from existing theories (Braun and Clarke 2013). The data were coded for semantic and latent codes. The semantic codes were data derived from a succinct summary of the explicit content. The latent codes were implicit interpretations of the data (Willig 2014). The initial and intermediate codes were used to create two working thematic maps developed to identify potential patterns in potential themes. This led to a final thematic map with three overarching themes and subthemes.

## Interview Schedule Design

The development and design of this study were informed by practice-based evidence derived from first-hand experience of working with patients seen at SEDS. This led to the ideas explored in the interviews. The interview schedule for this study was based on a pilot study conducted with a therapist who had worked in SEDS and the interview schedule was adapted accordingly.

## Results

### Theme 1: Notions of Shame as a Barrier

Participants used ‘stigma’ and ‘shame’ to describe how they believed ethnic minority females and their families experienced the ED diagnosis. Participants also expected this to act as a barrier to receiving help. Shame was referred to as a nebulous concept as opposed to fixed. Participants had different ideas about shame and how it works in other cultures, and this appeared to influence their therapeutic work. This included not challenging shame or assuming EDs are taboo in certain cultures, and linking this to a negative interpretation of parents. The subthemes are described in the following sections (Fig. 1).

#### *Subtheme 1: Reduced Family Support*

In the following extract, Participant 6 explains how she thinks that stigma surrounding mental health can make it difficult for ethnic minority families to discuss and seek help for their child:

...because for whatever reason, it hasn't been picked up at home, maybe because of a stigma thing or within their culture it is kind of taboo to talk about and then it actually took the teacher to notice. (Participant 6, Line 55–58)

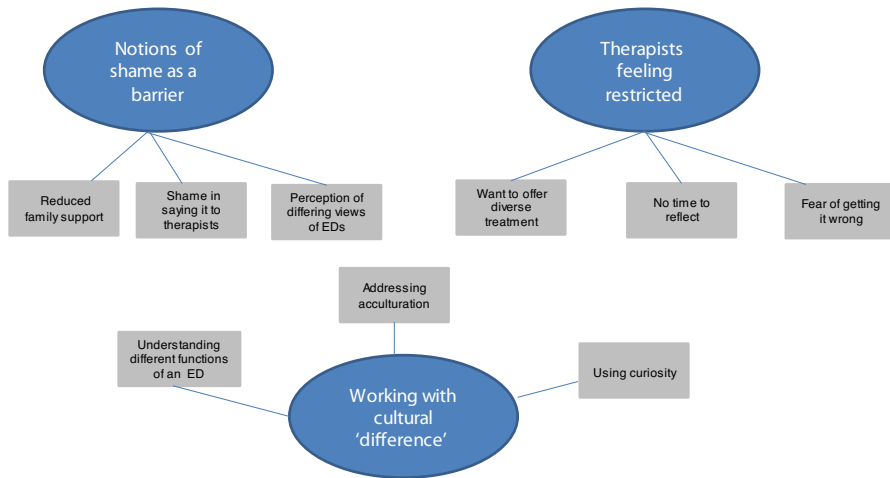
Participant 6 suggests that ‘it has not been picked up at home’ and implies this is due to the patient’s culture. This may be seen to cast blame on the parents and implies they have been neglectful (i.e. rather than not wanting to contact services because they believe they can help their child best, for example). Focussing on ethnicity restricts a wider observation that topics around the body are potentially a source of shame and reticence, not solely for ethnic minority people.

#### *Subtheme 2: Shame in Saying it to Therapists*

Participants perceived shame to impact how ethnic minority females communicated their needs to therapists and SEDS. Specifically, there was a perception that distress was not communicated or that there was an avoidance of talking about mental health, instead favouring the physical health perspective.

Participants explained that females communicated they were unable to eat due to problems with their stomach or gastrointestinal issues. Here, Participant 2 describes how people she provided therapy for described not eating due to physical stomach problems:

...thinking there's some kind of like stomach problem or gastro problem or something like that. And understanding not eating from that kind of physical health perspective. And maybe having that investigated, but nothing being found and then people coming to the eating disorder service instead (Participant 2, Line, 111 to 115)



**Fig. 1** Map of overarching themes and subthemes

Furthermore, Participant 2's reference to the 'stomach' as a cause for not being able to eat implies a recognition of an enmeshed distinction between the mind and the body. She has cautiously suggested that this presentation could explain a delayed and complicated route to accessing ED services.

### *Subtheme 3: Perception of Differing Views of Eating Disorders*

Participants perceived that ethnic minorities had differing views of EDs and that this was rooted in shame. This was thought to be due to ethnic minorities' lack of experience with their difficulties:

...just mental health as a concept and that can be quite scary because people may think that it's going to be, this is something permanent that their children are going to be kind of marked for life if anybody hears about one of their children being, having a mental health illness may impact everybody else's chances in life. (Participant 8, Line 186–190).

For example, Participant 8 explained how the ED label, which is a mental health diagnosis, was perceived to have a cultural narrative synonymous with exclusion from society, blame, and permanent scars. He interprets this observation as impacting not just the individual's health, but also their future and wider family. In this extract, Participant 8 appears to empathise and understand the patients' position that mental health problems can be 'quite scary'.

Participant 5 understood this stigma to be rooted in the way in which EDs were conceptualised, from a different cultural viewpoint:

I think there's different conceptualisation. So I've worked with one African girl and their family where they saw it as being like, possessed by like a jinn



and how for that, you wouldn't necessarily go to a doctor you, you would go to sort of more, turn to religion (Participant 5, Line 284–286)

Participant 5's comments here suggest that the ED has been understood in a way that does not fit with western views of mental health. She notices a different conceptualisation and seems to understand the family's actions reflect their interpretation of the ED as a possession. Nevertheless, there is a noticing of this perception being different and explaining delayed help-seeking.

## **Theme 2: Working with 'Cultural Difference'**

Some participants admitted to previously holding the belief that EDs are more likely to be associated with White or western females. Participant 8 referred to the 'evidence' which suggests that he is comparing the patients that he has worked with the research evidence on EDs, which is primarily based on western populations. There appears to be a disconnection between therapists' practice-based evidence and what is learnt from the research and literature:

I wouldn't have expected it because of the kind of, the myth about eating disorders very much a kind of White European or North American illness, but then there is lots of evidence that it's not the case, just they present in slightly different ways. (Participant 8, Line 99–102)

### *Subtheme 1: Understanding Different Functions of an Eating Disorder*

The following section provides quotes that all explore the different ways participants interpreted the factors fuelling the disordered eating and psychological distress.

But it's a control of emotions, for example, with ethnic groups, like, for example, starving themselves, you're controlling something, but it's not really weight and shape, doesn't come out as much. So, I have had this battle with certain clients where I'm for example using the cognitive behavioural therapy (CBT model). (Participant 4, Line 514–518)

...I might face some resistance because the person doesn't really identify with that. (Participant 4, Line 519–520)

Participant 4 described a 'battle' when trying to work with ethnic minority females. She related the feeling that there was a mismatch between the evidence-based cognitive behavioural therapy (CBT) model that guides her work and what the patient presents within therapy. She experienced feelings of resistance which she places externally because the patient does not fit or identify with the therapy model. Although she does not explain how this impacted the patient's care, it is noted that the use of words such as 'battle' and 'person does not identify' primarily focuses on the patient, as opposed to the CBT model.

### *Subtheme 2: Addressing Acculturation*

Participants observed that within ethnic groups, there were different levels of acculturation to western norms:

And this one girl, she was 15. She was quite heavily influenced by media. But she was born in this country. So, her ideas around beauty and thinness, which was constantly on Instagram. She was very influenced by western ideas. The other people I've worked with were all a lot older. And I think they were all people that had immigrated here. So, I don't think they have the same kind of western ideas around beauty. (Participant 3, Line 721–725)

In Participant 3's quote, she notices differences in western influence between first- and second-generation ethnic minority females. Participant 3 has linked increased exposure to western social media to being influenced by western beauty norms and therefore being at increased risk of ED. She implies this is something that has a more significant impact on younger patients. Participant 3 links the risk of western influence to more significant impact on younger patients and increased risk of EDs.

### *Subtheme 3: Using Curiosity*

Most participants reported using curiosity to attend to cultural differences and adapt therapy accordingly. Across the quotes, there is an unquestioned notion that cultural differences do exist, are relevant to the ED, and are useful to consider. This idea of cultural difference plays out in so many ways and has many repercussions in terms of therapy. However, therapists' ideas of what cultural difference means are based on various notions that may not always be linked to what their patients tell them. Consequently, whether differences are approached with a curious stance or challenged, is also dependent on therapists' interpretations.

Participant 1 referred to going beyond the idea of having an 'expert position' instead of advocating learning from the patient:

I think we just have to kind of, go beyond our knowledge, we sometimes have to approach that with curiosity about things about understanding and about taking that into consideration. It's a tricky balance though because we don't want to do it in a routine fashion. (Participant 1, Line 498–501)

In Participant 1's extract, she describes approaching therapy with curiosity, suggesting going into the unknown without formal guidance. She describes a 'tricky balance', suggesting a process that is tentative and adjusted.

Participant 9 referred to using curiosity, but this was nuanced since she feels she might have more permission to be curious about a client's culture, given her ethnic minority status.

I don't necessarily think there's more awareness or sensitivity, what I think is that I feel, and it might just be me that I have more permission, I have... It's

easier for me to ask, because I'm a minority as well, even though I might not be the same minority. (Participant 9, Line 173–175).

Nevertheless, she was keen to state that this did not make her more 'sensitive' than white therapists. She described using the notion of shared identity and the experience of being an ethnic minority to navigate therapy with her patients—even if the specific cultural nuances were thought to be different.

### **Theme 3: Therapists Feeling Restricted**

All participants described a sense of restriction in their clinical work with ethnic minority females and a desire to adapt and tailor work for this group effectively. Restrictions were perceived to arise from structures such as the NICE guidelines and limited amounts of clinical time and training dedicated to cultural factors. Lastly, there was a fear of being culturally offensive or doing something wrong.

#### *Subtheme 1: Wanting to Offer Diverse Therapy*

Participants expressed a keen desire to offer a broader range of therapeutic models or adaptations to suit the needs of their ethnic minority patients. For example, Participant 7 suggested a split between the service managers 'at the top' and therapists 'at the bottom':

So, the people that were at the bottom doing the actual clinical work wanted diversity. They wanted to use different models. But I think it was coming from top-down, less of the clinical staff much more of the management team. And I think it's just it's just politics. It's just people who make those guidelines, erm, kind of enforcing kind of... (Participant 7, Line 315–319)

In this extract, in using the word 'enforcing,' Participant 7 implies a sense of in-fighting related to the service management. This group, she feels, has strict rules about what therapies should be offered by therapists. This conflicts with what she deems to be the ethos of the therapists themselves.

#### *Subtheme 2: No Time to Reflect*

Participants suggested that the desire to provide cultural adaptations was further restricted by time constraints. There was often not enough time to reflect on clinical work or learn how it could be adapted. Participant 10 explained how reflection on culture should be interwoven into every aspect of the work:

I think it needs to be part of, to try and entangle it in all the work that we do. I think like many things, there wasn't always the time to include that thinking. So, I don't think, I don't know if it's like gaps in my knowledge or if it's more like the time to think that might be more of what's missing sometimes. (Participant 10, Line 398–402)

Much of a therapist's work requires being able to step back and reflect on what has been said in the session. However, Participant 10 describes not even having time to think. This implies a sense of exhaustion and feeling unsupported. Participant 10 seems unsure about whether cultural adaptations are given enough time and appears to implicate both time, and gaps in her own knowledge.

### *Subtheme 3: Fear of Getting it Wrong*

Participants explained that they were keen to address differences but sometimes worried about making incorrect assumptions about a client's culture or saying something offensive:

I think I have become a lot more confident at just um, being quite I used to be quite nervous about saying anything about culture in case someone thought I was being offensive or if someone thought I was putting up a barrier between us... (Participant 11, Line 119–121)

Participant 11 describes a nervousness that existed more in the past. In her extract, she explains how she feared endangering the therapeutic alliance by saying something unintentionally offensive and creating a 'barrier'. However, in the present, she describes an increasing confidence in the issue.

Fear was not just experienced when addressing culture with clients. The fear appeared is present within the extended system of SEDS:

I think people get really defensive. And that's not necessarily what they're trying to say, I certainly wasn't saying that just because we're not adapting treatments it's racist. (Participant 12, Line 539–541)

Participant 12 explained that she was fearful of mentioning the need to consider culture in therapy in multidisciplinary meetings. Participant 12 explains she perceived defensiveness from others when she proposed addressing culture and that she felt her comments were interpreted as criticism or 'racism' towards the system.

## **Discussion**

This research set out to explore ethnic minority females with EDs through the perspective of therapists in terms of what working with this group means to the therapists themselves and how therapists perceive and work with cultural concepts. The study revealed the barriers to accessing therapy, which include shame and service criteria for accessing treatment. Importantly, the research indicates that therapists have unmet needs, and require support, time, and resources to effectively meet the needs of their ethnic minority patients. The following explores the themes and how they fit within the broader evidence base, followed by recommendations for clinical practice and limitations of the study.

## Theme 1: Notions of Shame as a Barrier

Participants reported a belief that shame impacted how females used therapy or accessed treatment. The present finding from the participants complements findings by three other UK studies which also suggest that shame is a barrier for ethnic minority people accessing treatment (Channa et al. 2019; Chowbey et al. 2012; Wales et al. 2017).

It was thought that the family's shame about the ED led to less support in recovery. Research has suggested that parents often fear being blamed for the ED, regardless of ethnicity (Stillar et al. 2016). This interpretation influenced how therapists worked with this group, often in the form of not challenging the patient's desire to exclude parents. Therapists linked reduced parental involvement to their culture, where they assumed the ED is considered taboo. While in some cases there may be some substance to these beliefs, therapists' ideas can themselves become barriers or otherwise prohibitive. Moreover, the interpretation of a person's behaviours from a different culture is known to reduce the accuracy of emotion recognition (Wickline, Bailey, and Nowicki 2009).

Participants felt that female patients' families also expressed explanations of EDs, which put physical conceptualisations ahead of discourse around psychological distress. Aligned with this is research that has suggested that some people in the Asian community look for physical causes, such as a 'thyroid disorder', to explain the weight changes seen in EDs (Wales et al. 2017). Therapists queried whether this expression might be due to minimising weight and shape concern due to shame. Research indicates that in non-fat phobia there is a minimising response style (Izquierdo et al. 2019). However, another explanation is that linguistic and cultural differences between the therapist and patient might also explain the variations in illness beliefs and how these are expressed (Lanzara, Scipioni, and Conti 2019). This might be influenced, for example, by eastern paradigms of illness that might be more likely to focus on models of mind–body continuation which differ from western paradigms of mind/body dualism (Fernando 2004).

Non-fat phobia is distinct from avoidance restrictive food intake disorder (ARFID). An implicit association test study showed that those with non-fat-phobic anorexia and fat-phobic anorexia showed a greater association with pro-dieting than those with ARFID or healthy controls (Izquierdo et al. 2019). The DSM-5 has acknowledged non-fat phobia as potentially more common in Asian cultures and for clinicians to hold this in mind when considering diagnosis. Specifically, it refers to complaints of gastrointestinal discomfort that could be a warning sign of an ED which is more common in Asian cultures (American Psychiatric Association 2013). Non-fat phobia is not yet formally classified as an ED and this could partly explain why Asian females are under-represented in SEDS. Indeed, participants felt that in such cases, GPs might rule out an ED in the face of complaints of stomach discomfort or amenorrhoea and instead refer individuals to gastroenterology or gynaecology. This would inevitably create a more complex and delayed pathway to SEDS and delay referral, as the therapists in the present study noted. A complex pathway is noted for ethnic minority people in general when accessing mental health services (Bhui et al. 2003).

Participants suggested that the ‘differing view’ of EDs which they understood such groups to hold (and which increased associated shame), might be due to differences in education, ‘reduced awareness’, or a non-western way of understanding distress. For example, two therapists made references to females and their families understanding the ED to be caused by *jinn*—a form of spiritual possession. In such cases, females might be expressing psychological distress in a form that has meaning for them in the (non-western) context in which it was generated (Bentall and Pilgrim 1999). Therapists confronted with such ideas that without an appreciation for the patient’s context might perceive them to reflect a ‘reduced awareness’. This is perhaps dismissive of ways of experiencing psychological distress that exist outside of more familiar, western modes of understanding.

## **Theme 2: Working with ‘Cultural Difference’**

Participants suggested that in ethnic minority females, distress was thought to be a response to their immediate surroundings and interpersonal settings, or family dynamics. Indeed, this might also reflect a bias at referral whereby individuals from ethnic minority backgrounds are required to reach a higher clinical threshold before being referred (Ratan, Gandhi, and Palmer 1998; Waller et al. 2009).

Nevertheless, this was described as a ‘challenge’ since these features did not map onto the diagnostic or therapy models to which participants were accustomed. As such, the strong focus on ‘weight and shape concern’ by one of the most recommended therapies for EDs, that is the CBT-E model (i.e. Enhanced CBT for EDs), may subtly exclude those females who present with different ED causes, such as interpersonal or emotional factors (Fairburn 2008). In such cases, Interpersonal Psychotherapy may be an effective alternative despite the response to treatment being slower to be expressed (Fairburn et al. 2015).

The participants recognised acculturation as a specific risk factor for EDs in the ethnic minority females they worked with. This is also supported by a recent systematic review (Doris et al. 2015). Indeed, ethnic identity has a unique meaning to every individual within any ethnic group (Duncan and Trejo 2017). Participants suggested that acculturation levels might differ, with young people being more strongly influenced than perhaps older ethnic minority females or those who had recently migrated.

Participants reported using curiosity to guide their therapeutic work and tailor to cultural differences, which is in line with Milan systemic therapy models (Ceccin 1992). However, the present research revealed a duality between the notions of using ‘curiosity’ and feeling ‘uncertain’. This may be viewed as parallel to the concept of ‘cultural humility’ which has been cited in the literature. Here, it is acknowledged that a person does not know everything about cultures other than their own. As such, learning is treated as a lifelong process that entails a humble approach that is open to challenging cultural biases (Foronda, Baptiste, Reinholdt, and Ousman 2016). Nevertheless, participants in the present study did not acknowledge that their own interpretation appeared to largely determine whether a cultural behaviour (e.g. fasting) was approached with curiosity and validation or

challenged as part of the ED. It is often not possible to be value-free and objective when working with patients of different or similar cultural background.

### Theme 3: Therapists Feeling Restricted

A consistent theme was whether the NICE (2017) guidelines, which are largely based on research of western participants, could be applied appropriately to ethnic minority females. It was felt that service management wanted a stricter delivery of NICE-guided treatment. Therapists themselves insisted they wanted to have the flexibility to deliver a broader range of interventions that could address cultural nuances and complexities.

It has been argued that working with the physical risk of EDs adds anxiety to the therapeutic context for therapists (Eisler, Simic, Blessitt, and Dodge 2016; Mason 1993). Therefore, the sense of restriction may not only originate from services but also participants' anxiety about addressing cultural difference. It has been acknowledged that insufficient knowledge may also be a barrier to therapists adapting therapy protocols (McEvoy et al. 2017). Without an established evidence base for therapies demonstrated in ethnic minority females, the responsibility falls to the therapist to devise any necessary adaptations. This can inevitably feel uncertain and tentative. Moreover, the time and resource required to adapt treatments should not be underestimated. In the field of 'psychosis', a culturally sensitive adaptation of CBT required gaining views from patients with a diagnosis of 'schizophrenia', lay members from ethnic minority groups, CBT therapists, and mental health practitioners (Rathod, Kingdon, Phiri, and Gobbi 2010).

Participants reported feeling restricted by a lack of time to reflect on cultural issues. Culturally sensitive provision requires more time and consideration of how to address barriers such as language difference, use of interpreters, increased awareness, and working with discrimination (Bignall, Jeraj, Helsby, and Butt 2019). Within this theme, there was the desire for ongoing training on cultural issues to be provided through co-production with patients. Participants also suggested the potential value of being able to visit patients in their family home. This approach could help to consider cultural scripts around food and eating, and also work with the broader context of wider social issues, inequalities, and individual meanings (Johnstone and Boyle 2018).

Therapists expressed a fear of getting it wrong which played out on a personal or human level in worry about saying something unintentionally offensive about the patient's culture and creating a 'barrier' in therapy. Therapists from ethnic minority backgrounds ( $n = 4$ ) reflected on their cultural backgrounds and using that experience to navigate therapy. There was the expression of feeling that while they might have more permission to approach the subject of culture and race with their patients, there was also a fear of being judged by other team members for wanting or suggesting cultural adaptations. Confidence can also have an impact on the therapeutic alliance. Indeed, recent research has suggested that therapists who were externally rated as displaying racial and ethnic comfort when working with ethnic minority patients were better able to retain them in therapy and therefore not have premature termination of therapy (Owen et al. 2017). As such, by proxy,

reducing the feeling of fear of doing something wrong in therapists will lead to better outcomes for patients.

## Recommendations

There are several service-level and policy-level recommendations suggested, based on the present study's findings. With an added layer of intersectionality, that is, a cultural difference, therapists who work with females who are diagnosed with EDs may at times feel overwhelmed (Crenshaw 1989). These sources of anxiety may reduce creativity and flexibility in considering and providing cultural adaptations for ethnic minority females (Dodge 2019). As such, therapists must be given the time and space to consider cultural discourse in supervision, and with their colleagues in regular reflective practice that focuses on culture. Such spaces could have the effect of increasing therapist confidence and reducing the fear of approaching this topic, thereby facilitating cultural competency and nurturing a safer therapeutic partnership with the patient (Naz, Gregory, and Bahu 2019; Owen et al. 2017).

In therapy, there should be consideration of the inclusion of family that might exist in intergenerational households for some select sessions. Inclusion might be encouraged by the use of cultural genograms at the start of therapy and considering cultural scripts around food (Cronen and Pearce 1982; Hardy and Laszloffy 1995). This may help to ensure that information about EDs is communicated to the female and their family in a way that does not reinforce blame or shame (Castro-Vázquez 2019).

Participants expressed a desire for ongoing training on culture, to be co-produced with females who have been diagnosed with eating disorders. The demographic of the local area where the SEDS is located could be used to inform relevant cultural training geared towards the people in the catchment area who may require support at the service. The effect of training and greater practice-based knowledge will aim to reduce anxiety and thereby reduce the therapist's propensity to avoid instigating discussion of ethnicity, culture, and racism in therapy with their patients (Naz et al. 2019).

On a national level, SEDS and therapists could be provided with referral guides to support the recognition of EDs in ethnic minority people. This could also be provided in the earlier stages of the referral process, for example to teachers and GPs, and be available to families seeking help. These might include warning signs such as menstruating at a severely low weight, non-fat-phobic anorexia, somatic complaints, or the presence of interpersonal and emotional factors as ED drivers. Recommendations should aim to balance the nuances of the individual with a systematic rollout to address unmet needs. This might reduce the time and simplify the route taken to reach SEDS.

The under-representation of ethnic minority females at SEDS perhaps needs special attention through research and audits conducted in local services to address the demographics of the local area. Outreach programmes addressing these groups' unmet needs may also play an important role.



## Limitations

There was a conscious decision to ensure the sample was representative of the ethnic make-up of people in London. In the general population, it is estimated that those of Black and Asian ethnicity constitute 31.8% of London's population (Race Disparity Unit 2018). Ethnic minority participants appeared to be proportionally represented in this study, and they constituted 33% (4 out of 12) of the sample. Nevertheless, it is unclear whether this reflects the ethnic constitution of staff in SEDS. Ethnic minority therapists might have different perspectives on therapy due to lived experience of culture and/or shared ethnic identity.

Attention was paid to ensure the representation of a broad range of perspectives from the participant group. However, there is the possibility of selection bias through self-selection, whereby therapists who were more interested in the culture in EDs were more likely to take part. This may have led to rich data, but also a more limited perspective. This is because therapists who are less interested or inclined to acknowledge cultural differences are unlikely to feature in the present study's analysis.

## Conclusion

This research revealed therapists' enthusiasm for working with ethnic minorities in SEDs, albeit with perceived barriers from services themselves and the perception of shame. Indeed, one half of the therapeutic alliance is therapists, and their role and contribution should not be understated when aiming for positive outcomes for ethnic minority females.

Subtle steps can be taken to encourage new and creative ways of addressing the issues highlighted. The recommendations propose encouraging new ways of thinking about the problem, and of questioning concepts that are perhaps taken for granted. Services and guidelines should support therapists to encourage a curious stance, in the knowledge that this will encourage their creativity and comfort in providing culturally appropriate therapy.

**Acknowledgements** The author would like to thank the participating therapists, without whom this research would not have been possible, and Dr Lucy Serpell and Dr Soo Ling Lim are acknowledged for their support with the manuscript.

**Funding** This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

**Data availability** The datasets used during the current study are available from the corresponding author on reasonable request.

## Declarations

**Conflict of interest** On behalf of all authors, the corresponding author states that there is no conflict of interest.

## References

- American Psychiatric Association  
2013 Diagnostic and statistical manual of mental disorders. 5th Edition. Washington, DC: American Psychiatric Press.
- Becker, AE  
2007 Culture and eating disorders classification. *International Journal of Eating Disorders* 40(3):111–116. <https://doi.org/10.1002/eat.20435>.
- Becker, AE, A Hadley Arrindell, A Perloe, K Fay, and RH Striegel-Moore  
2010 A Qualitative Study of Perceived Social Barriers to Care for Eating Disorders: Perspectives from Ethnically Diverse Health Care Consumers. *Journal International Journal of Eating Disorders* 43(7):633–647. <https://doi.org/10.1002/eat.20755>.
- Bentall, D, and R Pilgrim  
1999 The Medicalisation of Misery: A Critical Realist Analysis of the Concept of Depression. *Journal of Mental Health* 8(3):261–274. <https://doi.org/10.1080/09638239917427>.
- Bhaskar, R, and B Danermark  
2006 Metatheory, Interdisciplinarity and Disability Research: A Critical Realist Perspective. *Scandinavian Journal of Disability Research* 8(4):278–297. <https://doi.org/10.1080/15017410600914329>.
- Bhui, K, S Stansfeld, S Hull, S Priebe, F Mole, and G Feder  
2003 Ethnic Variations in Pathways to and Use of Specialist Mental Health Services in the UK: Systematic Review. *The British Journal of Psychiatry* 182(2):105–116. <https://doi.org/10.1197/bjp.182.2.105>.
- Bignall, T., Jeraj, S., Helsby, E., and J. Butt  
2019 Racial disparities in mental health: Literature and evidence review. Retrieved from <https://raceequalityfoundation.org.uk/health-care/mental-health-report-published/>.
- Braun, V, and V Clarke  
2013 *Successful Qualitative Research: A Practical Guide for Beginners*. London: Sage.
- British Psychological Society  
2014 Code of Human Research Ethics (2nd edition). Retrieved from <https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf>.
- Castro-Vázquez, G  
2019 Japanese Men’s Embodied Culinary and Eating Practices: Health, Bodyweight Control, and the Male Self. *The Journal of Men’s Studies* 27(3):265–286. <https://doi.org/10.1177/1557988318763674>.
- Ceccin, G  
1992 Constructing Therapeutic Possibilities. In *Therapy as a Social Construction*. S McNamee and JK Gergen, eds., pp. 86–95. London, England: Sage Publications Ltd.
- Channa, S, A Lavis, C Connor, C Palmer, N Leung, and M Birchwood  
2019 Overlaps and Disjunctures: A Cultural Case Study of a British Indian Young Woman’s Experiences of Bulimia Nervosa. *Culture, Medicine and Psychiatry* 43(3):361–386. <https://doi.org/10.1007/s11013-019-09625-w>.
- Cheng, ZH, VL Perko, L Fuller-Marashi, JM Gau, and E Stice  
2019 Ethnic Differences in Eating Disorder Prevalence, Risk Factors, and Predictive Effects of Risk Factors Among Young Women. *Eating Behaviors* 32:23–30. <https://doi.org/10.1016/j.eatbeh.2018.11.004>.
- Chowbey, P, S Salway, and M Ismail  
2012 Influences on Diagnosis and Treatment of Eating Disorders Among Minority Ethnic People in

- the UK. *Journal of Public Mental Health* 11(2):54–64. <https://doi.org/10.1108/17465721211236363>.
- Crenshaw, K. W.  
1989 Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, 139–167.
- Cronen, VE, and WB Pearce  
1982 The Coordinated Management of Meaning: A Theory of Communication. In *Human Communication Theory*. FEX Dance, ed., pp. 61–89. New York: Harper & Row.
- DiAngelo, R  
2011 White Fragility. *The International Journal of Critical Pedagogy* 3(3):57–70.
- Dodge, E. (2019). *Engagement and connection - can we meet the challenges of working across cultures in eating disorder services*. Paper presented at the Eating Disorders and Culture Conference, London.
- Doris, E, I Shekrladze, N Javakhishvili, R Jones, J Treasure, and K Tchanturia  
2015 Is Cultural Change Associated with Eating Disorders? A Systematic Review of the Literature. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity* 20(2):149–160. <https://doi.org/10.1007/s40519-015-0189-9>.
- Duncan, B, and S Trejo  
2017 The Complexity of Immigrant Generations: Implications for Assessing the Socioeconomic Integration of Hispanics and Asians. *Industrial and Labour Relations Review* 70(5):1146–1175. <https://doi.org/10.1177/0019793916679613>.
- Eisler, I, Simic, M., Blessitt, E., and L. Dodge  
2016 Maudsley Service Manual for Child and Adolescent Eating Disorders. Retrieved from <https://www.national.slam.nhs.uk/wp-content/uploads/2011/11/Maudsley-Service-Manual-for-Child-and-Adolescent-Eating-Disorders-July-2016.pdf>.
- Fairburn, CG  
2008 *Cognitive Behavior Therapy and Eating Disorders*. London, England: Guilford Press.
- Fairburn, CG, S Bailey-Straebl, S Basden, HA Doll, R Jones, R Murphy, ME O'Connor, and Z Cooper  
2015 A transdiagnostic comparison of enhanced cognitive behaviour therapy (CBT-E) and interpersonal psychotherapy in the treatment of eating disorders. *Behaviour Research Therapy* 70:64–71. <https://doi.org/10.1016/j.brat.2015.04.010>.
- Fernando, S. 2004 Routledge.
- Fichter, MM, and N Quadflieg  
2016 Mortality in Eating Disorders-Results of a Large Prospective Clinical Longitudinal Study. *International Journal of Eating Disorders* 49(4):391–401. <https://doi.org/10.1002/eat.22501>.
- Fichter, MM, N Quadflieg, RD Crosby, and S Koch  
2017 Long-Term Outcome of Anorexia Nervosa: Results from a Large Clinical Longitudinal Study. *International Journal of Eating Disorders* 50(9):1018–1030. <https://doi.org/10.1002/eat.22736>.
- Flückiger, C, A Del Re, BE Wampold, and AO Horvath  
2018 The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis. *Psychotherapy* 55(4):316.
- Foronda, C, D-L Baptiste, MM Reinholdt, and K Ousman  
2016 Cultural Humility: A Concept Analysis. *Journal of Transcultural Nursing* 27(3):210–217. <https://doi.org/10.1177/1043659615592677>.
- Guest, G, A Bunce, and L Johnson  
2006 How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field methods* 18(1):59–82. <https://doi.org/10.1177/1525822X05279903>.
- Hardy, KV, and TA Laszloffy  
1995 The Cultural Genogram: Key to Training Culturally Competent Family Therapists. *Journal of Marital Family Therapy* 21(3):227–237. <https://doi.org/10.1111/j.1752-0606.1995.tb00158.x>.
- Izquierdo, A, F Plessow, KR Becker, CJ Mancuso, M Slattery, HB Murray, AS Hartmann, M Misra, EA Lawson, and KT Eddy  
2019 Implicit Attitudes Toward Dieting and Thinness Distinguish Fat-Phobic and Non-Fat-Phobic Anorexia Nervosa from Avoidant/Restrictive Food Intake Disorder in Adolescents. *Journal International Journal of Eating Disorders* 52(4):419–427. <https://doi.org/10.1002/eat.22981>.
- Johnstone, L., and M. Boyle  
2018 The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional

- psychiatric diagnosis. Retrieved from <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Main.pdf>.
- Joint Commissioning Panel for Mental Health  
2014 Guidance for commissioners of mental health services for people from black and minority ethnic communities. Retrieved from <https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf>.
- Khunti, K., Platt, L., Routen, A., and K. Abbasi  
2020 Covid-19 and Ethnic Minorities: An Urgent Agenda for Overdue Action. In: British Medical Journal Publishing Group.
- Lanzara, R, M Scipioni, and C Conti  
2019 A Clinical-Psychological Perspective on Somatization Among Immigrants: A Systematic Review. *Journal Frontiers in Psychology* 9:2792.
- Mason, B  
1993 Towards Positions of Safe Uncertainty. *Journal of Systemic Consultation and Management* 4:189–200.
- McEvoy, P, T Williamson, R Kada, D Frazer, C Dhliwayo, and L Gask  
2017 Improving Access to Mental Health Care in an Orthodox Jewish Community: A Critical Reflection Upon the Accommodation of Otherness. *BMC Health Services Research* 17(1):557. <https://doi.org/10.1186/s12913-017-2509-4>.
- Micali, N, MG Martini, JJ Thomas, KT Eddy, R Kothari, E Russell, CM Bulik, and J Treasure  
2017 Lifetime and 12-Month Prevalence of Eating Disorders Amongst Women in Mid-Life: A Population-Based Study of Diagnoses and Risk Factors. *BMC Medicine* 15(1):1–12. <https://doi.org/10.1186/s12916-016-0766-4>.
- National Collaborating Centre for Mental Health  
2015 Access and waiting time standard for children and young people with an eating disorder: Commissioning guide. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf>.
- Naz, S., Gregory, R., and M. Bahu  
2019 Addressing Issues of Race, Ethnicity and Culture in CBT to Support Therapists and Service Managers to Deliver Culturally Competent Therapy and Reduce Inequalities in Mental Health Provision for BAME Service Users. *The Cognitive Behaviour Therapist*, 12. <https://doi.org/10.1017/S1754470X19000060>.
- NICE 2017 NICE guidelines NG69: Eating Disorders Recognition and Treatment. Retrieved from <https://www.nice.org.uk/guidance/ng69/chapter/Recommendations>.
- Owen, J, J Drinane, KW Tao, JL Adelson, JN Hook, D Davis, and N Fookune  
2017 Racial/Ethnic Disparities in Client Unilateral Termination: The Role of Therapists' Cultural Comfort. *Psychotherapy Research* 27(1):102–111. <https://doi.org/10.1080/10503307.2015.1078517>.
- Price Waterhouse Coopers commissioned by BEAT  
2015 The Costs of Eating Disorders. Social, Health and Economic Impacts. Retrieved from <https://www.beateatingdisorders.org.uk/uploads/documents/2017/10/the-costs-of-eating-disorders-final-original.pdf>.
- Quadflieg, N, and MM Fichter  
2019 Long-Term Outcome of Inpatients with Bulimia Nervosa—Results from the Christina Barz Study. *International Journal of Eating Disorders* 52(7):834–845. <https://doi.org/10.1002/eat.23084>.
- Race Disparity Unit  
2018 Regional ethnic diversity: Gov.UK. Retrieved from <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest#ethnic-groups-by-area>.
- Ratan, D, D Gandhi, and R Palmer  
1998 Eating Disorders in British Asians. *International Journal of Eating Disorders* 24(1):101–105. [https://doi.org/10.1002/\(SICI\)1098-108X\(199807\)24:1<101::AID-EAT10>3.0.CO;2-3](https://doi.org/10.1002/(SICI)1098-108X(199807)24:1<101::AID-EAT10>3.0.CO;2-3).
- Rathod, S, D Kingdon, P Phiri, and M Gobbi  
2010 Developing Culturally Sensitive Cognitive Behaviour Therapy for Psychosis for Ethnic Minority Patients by Exploration and Incorporation of Service Users' and Health Professionals' Views and Opinions. *Behavioural Cognitive Psychotherapy* 38(5):511–533. <https://doi.org/10.1017/S1352465810000378>.

- Russell, G.M., and N.H. Kelly  
2002 *Research as interacting dialogic processes: Implications for reflexivity*. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research. <http://www.qualitative-research.net/index.php/fqs/article/view/831/1806>.
- Sim, L.  
2019 *Our Eating Disorders Blind Spot: Sex and Ethnic/Racial Disparities in Help-Seeking for Eating Disorders*. Paper presented at the Mayo Clinic Proceedings.
- Sinha, S, and N Warfa  
2013 Treatment of Eating Disorders Among Ethnic Minorities in Western Settings: A Systematic Review. *Psychiatria Danubina* 25(2):295–299.
- Sonneville, K, and S Lipson  
2018 Disparities in Eating Disorder Diagnosis and Treatment According to Weight Status, Race/Ethnicity, Socioeconomic Background, and Sex Among College Students. *International Journal of Eating Disorders* 51(6):518–526. <https://doi.org/10.1002/eat.22846>.
- Stillar, A, E Strahan, P Nash, N Files, J Scarborough, S Mayman, K Henderson, J Gusella, L Connors, and ES Orr  
2016 The Influence of Carer Fear and Self-Blame When Supporting a Loved One with an Eating Disorder. *Eating Disorders* 24(2):173–185. <https://doi.org/10.1080/10640266.2015.1133210>.
- Thompson, AR, and E Chambers  
2011 Ethical Issues in Qualitative Mental Health Research Introduction: Codes, Principles and Laws are Useful. *In* *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*. D Harper and AR Thompson, eds., pp. 22–37. West Sussex: John Wiley & Sons.
- Tong, A, P Sainsbury, and J Craig  
2007 Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-Item Checklist for Interviews and Focus Groups. *International Journal for Quality in Health Care* 19(6):349–357.
- Wales, J, N Brewin, R Raghavan, and J Arcelus  
2017 Exploring Barriers to South Asian Help-Seeking for Eating Disorders. *Mental Health Review Journal* 22(1):40–50. <https://doi.org/10.1108/MHRJ-09-2016-0017>.
- Waller, G, U Schmidt, J Treasure, F Emanuelli, J Alenya, J Crockett, and K Murray  
2009 Ethnic Origins of Patients Attending Specialist Eating Disorders Services in a Multiethnic Urban Catchment Area in the United Kingdom. *International Journal of Eating Disorders* 42(5):459–463. <https://doi.org/10.1002/eat.20631>.
- Wheatley, M  
1992 *Leadership and the New Science*. San Francisco: Berrett-Koehler.
- Wickline, VB, W Bailey, and S Nowicki  
2009 Cultural In-Group Advantage: Emotion Recognition in African American and European American Faces and Voices. *The Journal of Genetic Psychology* 170(1):5–30. <https://doi.org/10.3200/GNTP.170.1.5-30>.
- Willig, C.  
2014 *The SAGE Handbook of Qualitative Data Analysis*. London: SAGE Publications Ltd. Retrieved from <https://methods.sagepub.com/book/the-sage-handbook-of-qualitative-data-analysis>. <https://doi.org/10.4135/9781446282243>.
- World Health Organization  
2019 *The ICD-11 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (Vol. 2020)*. Geneva: World Health Organization.