

# MIDER

## Exploring barriers to South Asian help-seeking for eating disorders

Item Type	Article
Authors	Arcelus, Jon
Citation	Wales, J., Brewin, N., Raghavan, R. & Arcelus, J. (2017). Exploring barriers to South Asian help-seeking for eating disorders. <i>Mental Health Review Journal</i> , 22(1), pp.40-50.
Download date	2026-05-15 02:27:17
Link to Item	<a href="https://mider.dspace7.openrepository.com/handle/20.500.12904/8380">https://mider.dspace7.openrepository.com/handle/20.500.12904/8380</a>

**Title:** Exploring barriers to South Asian help-seeking for eating disorders

Wales, J., Brewin, N., Raghavan, R. & Arcelus, J. (2017). Exploring barriers to South Asian help-seeking for eating disorders. *Mental Health Review Journal*, 22(1), pp.40-50.

**Link to repository:**

<https://repository.nottinghamshirehealthcare.nhs.uk/handle/123456789/311>

**Additional information:**

Article as accepted for publication in *Mental Health Review Journal* published by Elsevier available at <http://dx.doi.org/10.1108/MHRJ-09-2016-0017>

© <year published>. This manuscript is made available under the CC-BY-NC-ND 4.0 license <http://creativecommons.org/licenses/by-nc-nd/4.0/>

**Publisher:** Elsevier

**Version note:**

The version presented here may differ from the published version or from the version of record. If you wish to cite the following item, it is advised to consult the publisher version. Access to the publisher version can be found via the repository URL listed above.

For more information about this article, or the research repository, please contact [repository@nottshc.nhs.uk](mailto:repository@nottshc.nhs.uk)

**Please cite the published version**

**Nottinghamshire Healthcare NHS Foundation Trust**  
Institutional Repository  
[repository.nottinghamshirehealthcare.nhs.uk](https://repository.nottinghamshirehealthcare.nhs.uk)

## **Exploring Barriers to South Asian Help-Seeking for Eating Disorders**

**Wales J, Brewin N (Leicester Partnership NHS Trust, Leicester, UK); Raghavan R ( De Montfort University, Leicester, UK); Jon Arcelus ( University of Nottingham, Nottingham UK)**

### **Abstract**

**Purpose** Referrals to specialist eating disorder services from the South Asian (SA) community are under-represented, despite research suggesting that disordered eating attitudes and behaviours of SA people are similar to the population in general. The study aimed to identify the reasons for this and sought to inform ways to encourage help-seeking.

**Design/Methodology/Approach** A qualitative methodology was used to investigate barriers to help-seeking for eating disorders among the SA community. A key informant focus group was conducted with clinicians working within the local specialist eating disorder service (participants n=16, 12 female, 4 male). Six focus groups were conducted with members of the SA community in Leicester, UK, (participants n=28, 23 female, 5 male) recruited from a local university, two charities and Children, Young People & Family Centres.

**Findings** A number of themes emerged as possible factors for delaying early access to help: lack of knowledge about eating disorders and their potential seriousness; ideals regarding body shape; family living circumstances, and the role of food in the community. Participants acknowledged stigma among their community associated with mental health issues, including eating disorders, and concerns about confidentiality when approaching services, particularly primary care.

**Originality/value** General practitioners and specialist services need to be aware of the potential barriers to help-seeking for eating disorders as early specialist help is recommended for effective treatment. An educational campaign around eating disorders specifically designed with the SA community in mind may improve awareness, reduce stigma and promote early help-seeking.

**Keywords** Eating disorders, help-seeking, barriers, mental health, South Asian, ethnicity

**Paper type** Research paper

## **Introduction**

Disordered eating (DE) refers to a wide range of abnormal eating behaviours that include excessive dieting and unhealthy weight control practices (Neumark-Sztainer *et al.*, 2011). The severity and frequency of behaviours is not enough to fulfill a diagnostic criteria for an eating disorder (ED), hence the use of subclinical eating disorders (ED's) or DE in the literature. DE has been shown to be an important risk factor for the development of ED's and a target for early prevention of ED development (Neumark-Sztainer *et al.*, 2011). ED's is a term covering the broad categories of anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED) as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2013).

Historically ED's were thought to be 'Western culture-bound syndromes' (Soh & Walter, 2013); however ED's are increasingly documented in diverse countries and cultures worldwide and appear to be increasing in, for example, the Asian regions with rising industrialisation, urbanisation and globalisation (Pike *et al.*, 2014). Pike and Dunne in their review of the rise of ED's in Asia (2015) suggest that ED's are not culture-bound or culture-specific, but culture-reactive. Soh and Walter (2013) found that African, Latin American and Hispanic groups were the most studied cultural groups with all other ethnic groups, including South Asian (SA) (those who originate from the Indian subcontinent), having few articles published on ED's. They concluded further research was required in this area to remove barriers to accessing care.

A number of studies have examined ED's among those from minority ethnic backgrounds in the UK. A recent population survey in South East London found a high prevalence of DE amongst minority ethnic populations, including SA (Solmi *et al.*, 2014). ~~These findings confirm previous studies from the United Kingdom (UK).~~ An earlier study in the UK showed that the prevalence of BN amongst schoolgirls from the SA community in Bradford was higher than for

their white counterparts (Mumford *et al.*, 1991). Bhugra and Bhui's study (2003) amongst teenagers in London showed differences across cultural groups with those from an 'Asian' background being significantly more likely, than those from a white or African-Caribbean background, to be compulsive eaters, to fast, and to think food dominated their lives. Despite these findings, referrals from members of this community to specialist ED services covering large SA populations are under-represented (Abbas *et al.*, 2010, Waller *et al.*, 2009, Button *et al.*, 1998). However, on referral to such services, no significant clinical differences between the SA and non-South Asian women have been found (Abbas *et al.*, 2010).

Waller and colleagues (2009) hypothesised that the low number of SA people accessing ED specialist services may be explained by the lack of identification at primary care level. Another possible explanation maybe the fact that SA people do not present at primary care services requesting help for ED or DE. The National Psychiatric Morbidity Survey in the United Kingdom (UK) may explain this trend as data showed SA people suffering from mental health problems were less likely to contact their GPs compared to their white and black counterparts (Cooper *et al.*, 2013). Whilst the survey did not explore the reasons why minority ethnic people may be less likely to consult their GP for mental health problems they noted reasons cited by other researchers. For SA with dementia, a sense of stigma and a lack of knowledge about mental illness and services alongside disillusionment with doctors and exclusion from services (La Fontaine *et al.* 2007) were reported. Also for dementia was the feeling that care is a family responsibility (Mukadam *et al.*, 2010). Fountain and Hicks (2010) in their study with a large proportion of Asian participants found fear of stigma and shame may prevent those with mental health problems from seeking help. Other studies have indicated that individuals of SA origin may somatise psychological distress, presenting to services in the form of physical complaints rather than mental health issues (EMPIRIC report, 2002).

Chowbey and colleagues (2012) aimed to explore the influences on diagnosis and treatment of ED's among people from minority ethnic communities using a qualitative methodology. Although the authors did not exclusively look at the SA population their findings are of interest.

The study found that low awareness of ED's particularly among older people was an important barrier to early help-seeking. ~~This study was limited by including people from different minority ethnic communities, which does not make it generalizable to the whole SA population living in the UK.~~

In order to reduce healthcare inequalities for those from a SA background in the UK, this study aimed to identify barriers to help-seeking for ED's among this community using a qualitative methodology. The findings are expected to provide information to facilitate help-seeking for ED & DE and improve access to specialist services for members of the SA community. Given the dearth of research in this area a qualitative inductive approach was seen as appropriate. One of the main advantages of this methodology is the rich, in-depth understanding of participant experience it provides.

## **Method**

The study took place in 2015 in Leicester, a city in the Midlands of England, UK with a high SA population. According to the most recent census data, just under one-third (31.8%) of the population living in the city identifies as SA (Asian/British Asian Indian, Pakistani or Bangladeshi) (ONS, Census 2011).

### *Recruitment and Participants:*

South Asian community: Six focus groups with members of the local community who self-identified as SA were undertaken. The groups included younger and older individuals, those who were migrants and those who were born in the UK. Both men and women were invited to attend. Recruitment was enabled through a University, two local charities and Children, Young People & Family (CYP&F) Centres. Recruitment for the University group was via posters at the university, an email to students, and a student careers fair. Interested students were given or emailed a participant information sheet. Recruitment for the charity and community groups was enabled by the researchers attending the centres where they were able to present the study. Those interested were provided with participant information sheets and a time and date

for the focus group. Focus groups were held on the university campus and at the charity & CYP&F centres as appropriate. All participants gave written consent prior to the initiation of the study and received a £10 gift voucher for their attendance.

A total of 28 people participated in the groups, 23 women and 5 men. Of the six focus groups two were conducted with young people aged 18-25 years, these were a mix of men and women, four were conducted with women aged between 25-65 years of age.

Clinicians from specialised services: Every member of the local specialised ED service was provided with an open invitation to participate in a focus group for clinicians via email. This key informant group was included to provide the reflective experiences of working with individuals from a SA background.

A total of 16 ED professionals took part in the focus group (4 males, 12 females) and included consultant psychiatrists, ED therapists, staff from a specialist ED inpatient ward and a clinical psychologist. The clinicians' experience of treating people with ED's ranged from 1 to 25 years.

The research study was approved by the Research Ethics Committee of De Montfort University and the local NHS Research & Development office.

*Insert Table 1 about here*

#### *Interviews:*

All the focus groups were conducted by the same experienced, qualitative interviewer (JW). All groups were conducted in English. An interpreter was present for three of the community focus groups who provided translation, as required, into Gujarati. The groups lasted for

approximately one hour. Focus groups were audio-recorded and subsequently transcribed verbatim.

A semi-structured interview schedule was developed by the research team to address the specific research questions outlined earlier. The participants from the local community were invited to comment on: attitudes towards mental health issues, particularly ED's and DE; awareness and understanding of ED's; where and when help would be sought; barriers to accessing care and how to encourage help-seeking. The interview schedule was continually modified to incorporate emerging themes from the focus groups. The clinicians were asked to note, in particular, any barriers to help-seeking they had encountered in treating individuals from this community suffering from an ED.

#### Data analysis

Thematic analysis was employed to examine the focus group transcripts. This provides a rich description of the data set which highlights the most prominent and important themes (Braun & Clarke, 2006). Data analysis was undertaken by the first author (JW). Initial ideas for coding were generated through familiarisation with the transcripts and the data were transferred into NVivo 11 (QSR, 2015). Codes were sorted into potential themes which were reviewed and refined during on-going analysis and discussion with other authors (JA & NB). All quotations used have been anonymised.

#### **Results**

The information from all the focus groups (people in the community and clinicians) was used to reach the themes. Thematic analysis revealed three main core themes: 1) Cultural aspects affecting the identification of ED's and/or DE in the SA community living in the UK; 2) Barriers to help-seeking and access to services for the treatment of ED's; 3) Suggestions for improving help-seeking and access to services. A summary of the themes and sub-themes can be found in table 2.

*Insert table 2 about here*

## **Theme 1. Cultural aspects affecting the identification of eating disorders/disordered eating**

Cultural aspects related to eating may make the recognition of problematic eating behaviour more difficult.

### *1.1 The positive view of thinness:*

Many interviewees from the SA community explained that weight loss would almost always be commented on positively among the community. This was due to several factors. Some mentioned that, as obesity was a problem in the community, weight loss was seen as healthy. People were thought to be much more motivated to seek help for being overweight than underweight. It was unlikely that a person who had lost weight would be considered to be suffering from an ED although there was awareness that some people lost weight in an unhealthy way, such as starving themselves for a period of time rather than doing a gradual weight loss programme or exercise. There was a general lack of appreciation in the community of the risk of developing an ED if a person had lost a lot of weight, or ate in a disordered way.

*'A lot of people actually say we're not losing weight the right way, they don't exercise they're just starving themselves. So they might not be sick or whatever but they're just starving themselves and sometimes when they are starving themselves ... families and friends say 'you look nice' so it's quite a positive attitude towards it when it is not a very positive thing to do. So sometimes I think once they start getting positive compliments ... they carry it on'*  
*(Respondent 4, female, >25)*

Some people discussed the positive view of thinness in young people in order to get married. Being overweight in the SA community, especially for girls of marrying age, was seen negatively, and the pressure of not becoming overweight in order to marry was present from young age.

*'Culturally it's kind of when the girl gets to a certain age or a boy gets to a certain age it's about getting married so you need to be a certain weight or you won't find a partner. And I think sometimes parents do put that into children's heads. Like 'oh don't over eat now, you need to start losing weight now' so they talk about weight a lot...'* (Respondent 4, female >25)

However, once married it was noted to be less of an issue to be slim. Many said there was no pressure from either their partners or family to be a certain size.

#### *1.2 The role of food in the South Asian community:*

Many of the interviewees described the important role of food among their community. Food was always present at celebrations and it was an excuse to meet with others. It was thought that people who did not join in such occasions would be considered antisocial rather than experiencing difficulties around food.

*'...generally whenever we celebrate or do anything social it revolves around food and usually quite high fatty sugary foods and then we have the counter side where you are trying to stay in shape and control everything...a conflict particularly as an adult where your lives evolve you have a bigger social circle and family commitments ... I don't know, I think there's so much emphasis on food it makes it quite difficult.'* (Respondent 22, female >25)

*'If someone would not eat with others they wouldn't think there's something wrong with them, they'd think that she's being anti-social, and say you know why don't you want all this good food...what's wrong with you? It's lovely food... there's something not quite right but they wouldn't think that she needs or he needs support...I think my family would get quite angry if...there was an individual not eating or picking or you know saying 'I don't want this' all the*

*time. They'd think...there's all this lovely food about and it's like why aren't you eating this, being disrespectful' (Respondent 2, female >25)*

There was a general consensus that there was too much unhealthy food consumed in the SA community and overeating was commonplace at family and community events. This was seen as something of a conflict of interests as eating higher calorific foods was at odds with maintaining or losing weight.

*'The amount of oil...fried foods, fatty foods, sugary foods. I think that's what the other problem is. From a young age.....people don't know what a balanced diet is. It's always the chapatti with the oily curry...I think if you make a chicken salad (it's like) you haven't eaten today.'*  
(Respondent 28, female >25)

## **Theme 2. Barriers to help-seeking and access to services**

Several subthemes were found within this section that may act as barriers for people to access help when suffering from an ED or DE.

### *2.1 Lack of knowledge about eating disorders*

When discussing eating problems, people were more likely to mention obesity, diabetes and health issues associated with being overweight rather than ED's. It appeared that lack of knowledge, and understanding regarding ED's were dependent on several factors, such as age.

Younger, UK born, participants appeared to be more aware of ED's than older members of the community, especially those not born in the UK. Many of the older, but also a few of the younger participants, were not aware of the terms AN and BN but did recognise that they had seen, or knew of, people with DE. Participants were more aware of the term AN than BN. Some younger people noted that information on ED's had been taught in schools which had aided their awareness alongside other sources such as articles and programmes in the media.

Those aware of ED's recognised that both males and females were at risk of developing these, but that they were more common in females

*'I'm more aware if it because of the media, I see programmes about it I see magazine articles.'*

*(Respondent 15, female <25)*

Place of birth was also commented on as influencing knowledge about ED's and DE. It was mentioned that for those who had been born and brought up in a culture where food had been scarce, knowledge would be especially low and ED's perhaps not readily understood. This also meant that there may not have the language to express ED's and sufferers may have difficulty conveying what they were experiencing to older family members.

*'...our parents don't know much about it, especially if they're from places like India and Pakistan and Africa ...'* (Respondent 1, female >25)

*'Several (patients) have communicated how hard it is to communicate that (their ED) to their parents if the parents have limited English because the kids, the ones we see, don't have the language to go back and describe it'* (Clinician 2)

*'My grandma for example it didn't exist to them because they lived in a time when food was scarce anyway, so it was very different, you cooked your meal you ate it, it wasn't a big deal. I think our lifestyles have changed and that's kind of developed this'* (Respondent 21, female >25)

*'...what you'll have for a lot of the second generation girls...they won't have a history of eating disorder or a language for this whole thing of dieting and wanting to be thin ...because their mums will have come from India...then actually women didn't diet, you were lucky if you managed to find enough food ...So these girls will come from families where you don't have ...'oh yeah my mum always dieted'...that understanding of size...that will not be understood. So for them I think there will be that added sense of isolation actually they can't talk to perhaps their mothers, aunts about it.'* (Clinician 3)

## *2.2. Lack of understanding of the seriousness of ED*

Some participants explained that ED's were less serious than other problems associated with eating which can cause medical problems e.g. diabetes, and cholesterol which could lead to heart attacks. Participants also mentioned that ED's were less serious than other mental health problems e.g. schizophrenia, depression and anxiety and the fact that, in their view, it could easily be treated by eating more or less. Whilst a minority commented that specialist psychological help was needed a few mentioned that families would try to help the sufferer by taking them on holiday or for an outing. They believed that this would be sufficient to instigate a change in behaviours. There was a comment that some may view the world of 'talking therapies' with some scepticism, seeing it as 'a money making profession' rather than serious medicine.

*'I just think ... eating disorders they're easily fixed so why go seek help if you can do it yourself? ... You have your family, you have support you can fix it yourself. ...someone who has diabetes something like that is more severe & they need to go to a doctor. Someone who has anorexia, sort it out yourself.'* (Respondent 14, male <25)

## *2.3 Eating problems seeing as a physical problem*

Weight loss and weight gain were also likely to be associated with suffering from a physical problem rather than a mental health one. This was linked to those with a general lack of awareness about ED's.

*'I don't think in the South Asian community we think of eating disorders. If we see someone losing weight or gaining weight they think to the more traditional diseases and they tell you something like you might have thyroid problem...'* (Respondent 16, female <25)

## *2.4 Stigma associated with mental health:*

There was a clear indication that any mental health problem, which may be thought of as reflecting negatively on the family/individual, would aim to be hidden or at least not openly

discussed. Some thought this went wider than just mental health in that anything that may be thought of as being detrimental, whether health wise or not, would be kept hidden. ED's were no different to this.

*'A lot of that stems from people thinking about what others will think about that...the reason is not so much the problem itself but is what others will think of us ...will they see us as crazy mental people they don't want to associate with? I think that is the reason for the circle of secrecy. People are afraid how others how the wider society ...will see them' (Respondent 21, female >25)*

Many thought that families turned a blind eye to mental health problems and had an attitude of 'just getting on with it' rather than actively seeking help.

*'I think it's just they brush so much under the carpet like so many issues are coming through now this generation that wasn't dealt with. I think their objective when they came to the UK was come here settle, work, get a roof on top of their heads, everything else was just sort yourself out and that escalates now into problems I think. They continue doing that, they don't need to do it now because they've got a house they've built themselves up and their families are financially secure now but they still don't still see it as whatever, kind of blinded still.'*  
(Respondent 28, female >25)

Participants explained that if people were concerned about stigma and shame they were more likely to delay their presentation to services and this has implications for successful treatment. One of the clinicians noted that this was particularly true for Asian males.

*'I saw a young girl recently and she certainly presented very late. She's now in her early 20's but she's been purging since she was 11. Her brother says it's been known in the family, she's been a BMI of 14 for years now which is very sad as she's already chronic really in terms of how long she's been unwell...she's had no treatment at all. One of the barriers there is the family just not willing to think about mental health there's a big stigma, a barrier about that...'*  
(Clinician 1)

*'I've had 2 or 3 (Asian males) who were more bulimic who've presented years after it started, always avoided coming...the ones I've seen ... have been very ashamed...something that's hidden' (Clinician 2)*

There was a school of thought that people would be much more willing to access help for physical rather than mental health problems. This seemed to be because physical problems are more obvious, potentially more serious and can only get better with medical intervention. A minority saw the GP as dealing with physical problems only. Respondents thought sufferers were much more likely to seek help for a mental health problem once they were experiencing physical effects as a result of this. One of the clinicians noted that SA people can present to services citing physical issues for a mental health problem. This may be due to translation issues where they lack the language to relay the eating difficulties they are experiencing.

#### *2.5 Difficulties keeping privacy within the family*

It was noted how a person's living situation may hinder their help-seeking for mental health problems. An adult living with their extended family may find it difficult to attend regular therapy sessions if they do not want to share the reason for their absences with other family members.

*'I went to counselling once and I always made an excuse at that time of that week...I didn't want to tell my in-laws where I was going. Every week it was a coffee morning or something which then had its own problems, because 'she's always going out for coffee'...' (Respondent 22, female >25)*

#### *2.6 Worries about confidentiality*

There were some issues around approaching the GP. Whilst many acknowledged they understood healthcare professionals were bound by confidentiality there were some concerns around this. These concerns seemed to be related to health information being shared with other family members without patient authorisation.

*'...you all know the confidentiality rule applies but probably, self-consciously, they're thinking it won't apply because they're Asian communities' (Respondent 4, female >25)*

*'...one of the...Asian patients I worked with said she was really worried about coming because she was worried that her GP would tell... her parents that she'd been...I don't think it had happened to her but she perceived it as a worry and it delayed her going' (Clinician 4)*

Fear of confidentiality was not restricted to the GP as one of the clinicians noted that it was not unusual for a SA patient to request to see a non-SA therapist when presenting to specialist services.

*'It's not unusual to see an Asian patient has requested not to see an Asian therapist'*  
*(Clinician 5)*

### *2.7 The care pathway*

Many understood that GP's would need to refer patients to specialist services for treatment for an ED. This evoked some concerns about being taken seriously and a referral being made. Some thought that those who presented to their GP with an ED and who did not get referred for treatment initially may not seek help again.

### **Theme 3. How to improve help-seeking & access to services**

Participants were asked for suggestions for improving help-seeking and access to services for members of this community. Education was key for many, some commented that they had learnt about ED's at school, albeit briefly. Education was required firstly to raise awareness of ED's and secondly to highlight the seriousness and potential consequences of such disorders.

Some mentioned recent publicity about mental health problems within the SA community, a Bollywood actress who had depression and spoken openly about this, and the issue of autism being depicted in films had raised awareness of mental health and this was welcomed.

*'I think now some of the Bollywood films are now starting to put mental health issues into the films. ... things like autism as well that's into two of the major films ...but it's quite light-hearted...'* (Respondent 4, female >25)

Some commented that if issues were portrayed either on Asian TV channels or in everyday soap operas on television it could lead to family discussions about the issues raised.

*'...sometimes when we're watching EastEnders, Coronation Street and certain topics like this come up, normally as a family we discuss it, ... maybe not many Asian families have that discussion'* (Respondent 4, female >25)

Participants suggested using case studies (as part of the education to the community) from service users with a SA background detailing the reasons a person sought help, and the consequences of receiving help. Their view was that this could help those with little understanding of ED's to appreciate what they are, how they may manifest, what help is available and how to access care. Whilst there were varied levels of agreement about who listened to Asian radio, this appeared to be a useful forum for putting such information across. Generally participants thought listening to information was a better way to inform than having to read it so did like the idea of radio, television, films as well as workshops in school and colleges.

Participants thought that posters and leaflets would, on their own, have limited utility in improving understanding of ED's. However they may be of use alongside other sources of information provision. They could prove useful especially if they were put up outside of healthcare settings in community centres, mosques and temples. It may let people know that it is acceptable to talk about such issues and encourage discussion.

*'Maybe Asian community centres, temples and stuff, if they put them (posters) there they'd be like hold on a second why has that poster been put up here here? ... maybe that would be more helpful'* (Respondent 16, female <25)

*'The temples and mosques...they have noticeboards...that in itself would say maybe it is ok for us in this community to talk about eating disorders' (Clinician 3)*

It was thought that posters should depict a range of people, highlighting that anyone can suffer from an eating disorder, and they are not restricted to any gender, age or minority ethnic group.

*'It's not just for them so you wouldn't just have an Asian face on it, that's not what you are doing, you're just letting the Asians also be aware of it' (Respondent 24, female >25)*

The clinicians thought the focus of both leaflets and posters should be on not being ashamed of having an ED and not to suffer, but to seek help. Confidentiality, at point of contact with NHS services, should also be stressed.

*'I think another thing that would be good is defining what it is. Everybody's perception of anorexia or eating disorders may be different...'* (Respondent 22, female >25)

## **Discussion**

As the number of people from the SA community attending ED specialised services is low (Abbas *et al.*, 2010), the main aim of this study was to identify the barriers for help-seeking.

This study is not without limitations. This was an exploratory study with a small sample size of 44 individuals (mainly females) taking part in focus group discussions. The sample had wide age ranges, particularly for the older age group of 25-65 years; this had the benefit of including older members of the community, although no older men participated. It was limited to one city therefore the results may not be generalizable to other countries but it is likely to be generalizable within the UK. As the interviews took place in groups, some interviewees may not have been able to share their own experiences. The key informant focus group with 16 participants was too large and would have benefited from being two smaller groups. The participant information sheet stated the research was concerned with eating problems which, whilst necessary, may have affected participation by those with limited knowledge in this area being less likely to attend. Research did not include GP's who could have provided insight on

how and when help was sought by members of this community. In spite of the limitations this is the first study that focuses solely on the SA community living in the UK aimed at understanding what can professionals do to enable ED sufferers to access appropriate services. Future studies could seek to implement some of the recommendations and evaluate their effectiveness in ED help-seeking among this community. It would be prudent to investigate the key themes emerging from this research in larger, quantitative studies.

Previous studies that have explored access of care among people from minority ethnic groups with ED's have demonstrated the existence of cultural barriers among different communities (Chowbey *et al.*, 2012). In view of the importance of culture in the manifestation of ED's and access to help (Agüera *et al.*, submitted), this study focussed on one specific culture, the SA community living in the UK.

The study found that lack of awareness and understanding about ED's is potentially key in not seeking help when suffering from an ED or DE. As many people with ED lack the motivation to access help (Evans *et al.*, 2011), they do rely on family and friends to encourage help-seeking. Among the SA community a lack of awareness by other family members may delay the sourcing of professional help. Education, at all levels, would help recognition of ED's within the family and may also dispel myths that ED's are relatively trivial illnesses and potentially remedied without therapeutic intervention. This appeared not to be unique to ED's but mental health problems in general as several respondents explained that they would mainly attend the GP for physical problems. Indeed it was the medical complications from an ED which may encourage people to attend primary care services. These findings confirm a previous study among SA women receiving treatment for an ED (Hoque, 2011).

Lack of help-seeking also stemmed from concerns about stigma. This may lead people to either ignore or keep the issue within the family. This is a wider issue than just ED and will clearly take time to change, but education would appear to be the first step to widen understanding that mental health issues can affect anyone, and that those suffering from

mental health problems should not feel shame, be stigmatised or discriminated against. A recent analysis by Brown *et al.* (2014) found that SA people seeking informal help for mental health problems were most likely to do so from family rather than friends. This fear of stigma is not limited to the SA community. A recent systematic review by Clement *et al.* (2015) examining the impact of mental health-related stigma on help-seeking, whilst not ED specific, concluded that minority ethnic populations were disproportionately deterred by stigma.

Family living circumstances, especially those living in an extended family group, were also found to hinder help-seeking. This is allied with concerns that information may be shared, by healthcare professionals, with other family members even though they understood confidentiality issues. Confidentiality is an area that could be emphasized by healthcare professionals, particularly to this minority ethnic group.

The study also aimed to seek ways of improving access to specialist services for ED's. The study found that information regarding mental health problems including ED's displayed outside of healthcare settings e.g. in community centres & temples, could be helpful. This may promote discussion around mental health problems, including eating issues, and improve education. Many ED services are part of the NHS which has, for example, school nurses who could help deliver information about ED's and improve mental health literacy in general. Drop-in centres could be used to help members of this community access services, potentially for all mental health issues. This may allay concerns around the care pathway but would require investment. Whilst wanting to encourage all to seek help from specialist ED services where appropriate, for those who feel they are unable to access help in this way due to family circumstances or confidentiality fears, even if unfounded, self-help manuals, programmes and websites may have increased utility. Accessing such resources online could potentially be an ideal way to educate, inform and offer help. However in order to seek help, sufferers need to be aware of the signs and risks of ED's which can only be achieved through improved education. The media was mentioned as an important vehicle to both educate and inform about ED's. A recent study by Mukadam *et al.* (2015) also highlighted the need for personal

narratives to encourage help-seeking in the SA community, in this instance for dementia. Using local Asian radio stations to highlight ED case studies may be a useful way of informing, particularly older members of the SA community, about ED's and the treatments available. Whatever the route, steps need to be taken to reduce healthcare inequalities for those from a minority ethnic population.

## References

Abbas, S., Damani, S., Malik, I., Button, E., Aldridge, S. & Palmer, R.L. 2010. A comparative study of South Asian and non-Asian referrals to an eating disorders service in Leicester, UK. *European Eating Disorders Review*, Vol 18 No. 5, pp 404-9.

Agüera, Z., Brewin, N., Chen, J., Granero, R., Kang, Q., Fernández-Aranda, F. & Arcelus, J. 2016. Eating symptomatology and general psychopathology in patients with anorexia nervosa from China, UK and Spain: A cross-cultural study. Submitted

American Psychiatric Association 2013. *Diagnostic & statistical manual of mental disorders* (5th ed.). Washington DC, APA.

Bhugra, D. & Bhui, K. (2003). Eating disorders in teenagers in East London: a survey. *European Eating Disorders Review* 11:46-57

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.

Brown, J., Evans-Lacko, S., Aschan, L., Henderson, M.J., Hatch, S.L., & Hotopf, M. 2014. Seeking informal and formal help for mental health problems in the community: a secondary analysis from a psychiatric morbidity survey in South London. *BMC Psychiatry*, 14(1), p.1.

Button, E., Reveley, C. & Palmer, R.L. 1998. An ethnic comparison of eating attitudes and associated psychological problems in young British women. *International Journal of Eating Disorders*, 23 pp.317-323.

Chowbey, P., Salway, S. & Ismail, M., 2012. Influences on diagnosis and treatment of eating disorders among minority ethnic people in the UK. *Journal of Public Mental Health*, 11 (2) pp. 54-64.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsçh, N., Brown, J.S.L. and Thornicroft, G., 2015. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, 45(01), pp.11-27.

Cooper, C., Spiers, N., Livingston, G., Jenkins, R., Meltzer, H., Brugha, T., McManus, S., Weich, S. & Bebbington, P. 2013. Ethnic inequalities in the use of health services for common mental disorders in England. *Social psychiatry & psychiatric epidemiology* 48(5) pp. 685-692.

Evans, E.J., Hay, P. H., Mond, J., Paxton, S.J., Quirk, F., Rodgers, B., Jhajj, A.K. & Sawoniewska, M.A. 2011. Barriers to help-seeking in young women with eating disorders: A qualitative exploration in a longitudinal community survey. *Eating Disorders*, 19 pp. 270-285.

Fountain, J. & Hicks, J. (2010). Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008. International School for Communities, Rights and Inclusion (ISCRI), University Central Lancashire, Lancashire

Hoque, S. 2011. An exploration into the experience of an eating disorder and the journey into treatment for British South-Asian women: What can we learn? Doctorate thesis in Clinical Psychology, University of Leicester, Leicester, UK.

La Fontaine, J., Ahuja, J., Bradbury, N.M., Phillips, S. & Oyebode J.R. (2007) Understanding dementia amongst people in minority ethnic and cultural groups. *Journal of Advanced Nursing* 60(6) 605-614

Mumford, D.B., Whitehouse, A.M. & Platts, M. 1991. Sociocultural correlates of eating disorders among Asian schoolgirls in Bradford. *The British Journal of Psychiatry*, Vol 158, pp. 222-8.

Mukadam, N., Cooper C. & Livingston G. 2010. A systematic review of ethnicity and pathways to care in dementia. *International Journal of Geriatric Psychiatry* 26:12-20

Mukadam, N., Waugh A., Cooper C. & Livingston G. 2015. What would encourage help-seeking for memory problems among UK-based South Asians? A qualitative study. *British Medical Journal Open* 5:e007990

National Centre for Social Research (2002). Ethnic minority illness rates in the community (EMPIRIC) Quantitative Report. The Stationery Office, London

Neumark-Sztainer D., Wall M., Larson, N. I., Eisenberg M. E., Loth K. 2011. Dieting and disordered eating behaviors from adolescence to young adulthood: Findings from a 10 year longitudinal study. *Journal of the American Dietetic Association* 111(7):1004-11

NVivo, QSR International Pty Ltd. Version 11, 2015

Office of National Statistics, Census 2011, website:[infuse2011.ukdataservice.ac.uk](http://infuse2011.ukdataservice.ac.uk)  
accessed 24/08/2016

Pike, K.M., Hoek, H.W. & Dunne, P.E. (2014). Cultural trends and eating disorders. *Current Opinion in Psychiatry* 27:436-442

Pike, K.M. & Dunne, P.E. (2015). The rise of eating disorders in Asia: a review. *Journal of Eating Disorders* 3:33

Solmi, F., Hatch, S.L., Hotopf, M., Treasure, J. & Micali, N. 2014 Prevalence and correlates of disordered eating in a general population sample: the South East London Community (SELCoH) study. *Social psychiatry and psychiatric epidemiology* 49(8), pp. 1335-1346

Soh, N.L. & Walter, G (2013). Publications on cross-cultural aspects of eating disorders.  
*Journal of Eating Disorders* 1:4

Waller, G., Schmidt, U., Treasure, J., Emanuelli, F., Alenya J., Crockett, J. & Murray K. 2009.  
Ethnic origins of patients attending specialist eating disorder services in a multi-ethnic urban  
catchment area in the United Kingdom. *International Journal of Eating Disorders* 42 459-463