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CONCEPTUALIZATION OF BODY IMAGE AND EATING DISORDERS AMONG SOUTH  
ASIAN AMERICAN WOMEN: A QUALITATIVE INVESTIGATION

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science  
at Virginia Commonwealth University.

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Bachelors of Arts, University of California, Berkeley, May 2015

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Richmond, Virginia  
September 25<sup>th</sup>, 2019  
Thurston House, Room 102, 12:30-2:30 PM

## Acknowledgements

This work has been in the making for quite some time, and I am constantly reminded that no one succeeds alone. I am very grateful for the wonderful team of people who helped this idea blossom into – what I hope is – a meaningful contribution. I would like to start by extending my gratitude and sincere thanks to my primary advisor, Suzanne Mazzeo, for the amount of time and effort that she spent assisting me with this study. Her support is immeasurable. I would also like to thank my committee members, Kristina Hood and Maghboeba Mosavel, for their feedback and assistance, especially for providing expertise on conducting culturally-sensitive research. I would also like to thank my qualitative methods professor, Patricia Kinser, for her assistance with this proposal. Thank you to my research team members, Harlean Bajwa, Brogan Thomas, Rachel Boutte, and Preet Kaur, who all kindly volunteered their time to assist with this project. I would also like to thank Dr. Aashir Nasim and the VCU Institute for Inclusion, Inquiry and Innovation (iCubed) for their generous funding support for this study. Next, I would like to thank my family for their continuous love, support, and warmth – you all inspire me every day. I would like to also extend a special thanks to my partner for always encouraging me to go beyond anything that I thought I was capable of. Last, I would like to express my deepest gratitude to the wonderful women who took the time to share their stories with me – you all made this work worthwhile.

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## Abstract

### CONCEPTUALIZATION OF BODY IMAGE AND EATING DISORDERS AMONG SOUTH ASIAN AMERICAN WOMEN: A QUALITATIVE INVESTIGATION

By: Neha J. Goel, B.A.

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science  
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Virginia Commonwealth University, 2019

Committee Chair: Suzanne E. Mazzeo, Ph.D.  
Professor of Psychology  
Department of Psychology

Though it is known that eating disorders (EDs) affect individuals of all racial/ethnic backgrounds (Cheng, Perko, Fuller-Marashi, Gau, & Stice, 2019), people of color tend to be overlooked in the ED literature. South Asian Americans, a specific subset of individuals traditionally categorized within the larger umbrella group of “Asians,” have been notoriously neglected in both the broader mental health literature, and in the ED literature (Inman, Devdas, Spektor, & Pendse, 2014; Iyer & Haslam, 2003, 2006). Currently, very little information exists on the etiology and presentation of EDs amongst South Asian communities. Even less is known about culturally-specific barriers to treatment-seeking for this population. To begin to address these issues, this study used focus group methodology with South Asian American women to identify salient themes. Thematic analysis revealed several key themes for body image and EDs, as well as perceived barriers and facilitators of ED treatment-seeking behavior for this group. Notably, South Asian American women are subjected to multiple appearance ideals, experience unique cultural stressors related to living in the United States, and perceive relatively high expectations and pressures from multiple social domains, including parents and community members. Both generalized and social stigma about mental health, parents’ mental health

concerns, lack of knowledge about EDs, and healthcare providers' biases were important barriers to treatment-seeking. To address these obstacles, participants recommended that clinicians facilitate intergenerational conversations about mental health, create ED psychoeducational health campaigns, and train providers in culturally-sensitive practices for detecting and treating mental health and ED concerns. Findings can inform the assessment, prevention, and treatment of EDs via the development of a culturally-sensitive ED assessment measure designed specifically for South Asian American women.

*Keywords: eating disorders; body image; South Asians; Asian Americans; qualitative methods; multiculturalism*

## Conceptualization of Body Image and Eating Disorders among South Asian American Women:

### A Qualitative Investigation

Eating disorders (EDs) are serious mental health conditions associated with poor health outcomes, clinical impairment, and high rates of comorbidity and mortality (Klump, Bulik, Kaye, Treasure, & Tyson, 2009; Schaumberg et al., 2019). The American *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; American Psychiatric Association, 2013) recognizes three main ED diagnoses: anorexia nervosa (AN), which is characterized by a refusal to maintain a normal body weight that is accomplished via various methods of caloric restriction; bulimia nervosa (BN), which involves cycles of binge eating followed by use of compensatory behaviors; and binge eating disorder (BED), in which the hallmark symptom is recurrent episodes of binge eating characterized by consuming objectively large amounts of food coupled with a sensation of a loss of control.

Although it has been established that EDs are influenced by a variety of biological and sociocultural factors (Striegel-Moore & Bulik, 2007), these disorders were initially thought to only affect individuals living in Westernized countries, and as such, were regarded as “culturally-bound syndromes” (Prince, 1985). The hypothesis that EDs are “culturally-bound” stems from the sociocultural model of EDs, which posits that environmental and cultural factors play an important role in the development, manifestation, and presentation of eating pathology (Stice, 1994). This model is framed from a Western perspective, which promotes a thin, slender body as the ideal representation of beauty and femininity for women and regards the internalization of this thin-body ideal as a robust risk factor for EDs (Striegel-Moore & Bulik, 2007).



Much of the research on the assessment, etiology, and treatment of EDs among different cultural groups is grounded in this Western sociocultural perspective. However, results of more recent studies indicate that EDs affect individuals across various racial and ethnic stratifications, including groups that do not identify with primarily Westernized orientations (Cheng, Perko, Fuller-Marashi, Gau, & Stice, 2019). The current study investigates ED and body image concerns amongst a group that has been particularly underrepresented in the ED and broader mental health literature – South Asians (Inman, Devdas, Spektor, & Pendse, 2014; Iyer & Haslam, 2003, 2006).

According to the American Psychological Association (2017), the term “South Asians” refers to individuals descending from the subcontinent of India, including Bangladesh, Nepal, Pakistan, Sri Lanka, Bhutan, and the Maldives; (however, it should be noted that most studies did not include these last two countries within their criteria). In the clinical literature, traditionally, South Asians have not been assessed as an independent group, but rather, have been subsumed into the larger ethnic category of “Asians.” However, this is problematic considering that this categorization both minimizes the vast diversity among this larger ethnic group, and inadvertently masks unique differences in eating pathology within individual Asian groups (Cummins et al., 2005; Kennedy et al., 2004; Levinson & Brosos, 2016).

Thus, it might be misleading for researchers to generalize findings across Asian populations (Cummins, Simmons, & Zane, 2005; Kennedy et al., 2004). For example, research has demonstrated that various Asian cultural groups exhibit differential rates of both help-seeking and reporting ED symptoms to health care professionals (Lucero, Hicks, Bramlette, Brassington, & Welter, 1992). These findings suggest that there might be some underlying factor, or combination of factors, related to the unique cultural context of each Asian group that

contributes to these discrepancies. As such, it is imperative to enhance our understanding of the potential culturally-specific influences on the etiology, onset, and maintenance of EDs in South Asians specifically, especially as they have been relatively underrepresented in extant research.

Thus, the current study aims to clarify the underlying nature and etiology of ED psychopathology among South Asians by investigating how South Asian women living in the United States conceptualize these conditions. Specifically, this study attempts to answer the following questions: (1) how do South Asian women living in the United States understand and discuss body image and ED concerns, and (2) what are the barriers and facilitators to ED treatment for this population? To achieve this aim, this study utilized a qualitative approach involving focus groups to assess participants' experiences and understanding of: (1) ED psychopathology (i.e., symptomatology, cognitions), (2) ED-related constructs (e.g., internalization of the thin ideal, body dissatisfaction), and (3) culturally-influenced constructs (e.g., cultural conflict, internalization of the model minority stereotype), as a means of determining potential risk and protective factors for this group. These data will help identify facilitators and barriers to ED treatment and inform ED survey development for this population. This paper will begin by reviewing ED research conducted with South Asian populations.

### **Barriers to Mental Health and Eating Disorders Treatment among South Asians**

Psychological research with South Asian populations is limited, and has primarily focused on depression, acculturation and cultural adjustment, racial discrimination, mental health stigma, and barriers to help-seeking (Inman et al., 2014). In the United States and abroad, Asians, including South Asians, exhibit low rates of help-seeking and mental healthcare utilization (Fountain & Hicks, 2010; Gupta, Szymanski, & Leong, 2011; Panganamala & Plummer, 1998; Sue, Cheng, Saad, & Chu, 2012). Identified barriers to psychological help-

seeking for South Asians in the United States include racial discrimination, therapists' lack of knowledge about immigration and cultural experiences, both personal and perceived stigma and shame surrounding treatment-seeking, and conceptualizations of mental health and treatment that differ from those of Western medical practice (Arora, Metz, & Carlson, 2016; Fountain & Hicks, 2010; Inman et al., 2014; Sue et al., 2012). Additionally, internalization of the model minority stereotype, which postulates that Asians inherently possess positive characteristics, such as a strong work ethic, high academic achievement, and socioeconomic prosperity, is also a barrier to help-seeking for this group (Gupta et al., 2011). For South Asian American women in particular, lack of family support has been linked to both psychological distress generally (Masood, Okazaki, & Takeuchi, 2009), and eating disturbances specifically (Chang, Perera, & Kupfermann, 2014).

Asian Americans are vastly underrepresented in the ED literature relative to other marginalized groups (Chao et al., 2008; Yu, Perez, & Pope, 2019). Extant literature has identified a few key cultural factors as correlates of EDs in Asian populations (defined broadly). These include challenges related to reconciling the pressures associated with pursuing Eurocentric beauty standards (e.g., white skin, blue eyes, thin body shape), while simultaneously recognizing that this ideal is physically impossible for Asian women, high rates of both self-oriented and parent-oriented perfectionism, acculturative stress, sexual objectification, sexism, and racial discrimination (Brady et al., 2017; Chang, Yu, & Lin, 2014; Goel, Burnette, & Mazzeo, 2019; Iyer & Haslam, 2006; Mintz & Kashubeck, 1999; Perez, Voelz, Pettit, & Joiner, 2002; Yokoyama, 2008; Yu et al., 2019).

Research also shows that when members of ethnic minority groups (including Asians) seek ED treatment, they are less likely to receive appropriate referrals from physicians, and have

lower treatment uptake and access to care, relative to their White counterparts (Alegria et al., 2002; Becker, Franko, Speck, & Herzog, 2003; Marques et al., 2011). Furthermore, many Asian patients who present with EDs view their disorder as a physical, rather than a psychological, illness and first seek treatment from their primary care doctors. However, these professionals might not be trained to detect both typical and atypical presentations of ED symptoms (Button, Reveley, & Palmer, 1998; Dickerson et al., 2011; Striegel-Moore et al., 2008; Walsh, Wheat, & Freund, 2000). Additionally, even when South Asian patients present with a diagnostic profile for AN similar to that of their White counterparts, they are less likely to be diagnosed and referred to ED treatment, providing additional evidence of ED treatment biases against people of color (Abbas et al., 2010).

Patients themselves are also vulnerable to racial stereotypes concerning ED diagnoses. For example, when provided with vignettes of individuals from different ethnic backgrounds presenting with ED symptoms, White, Hispanic, and African American undergraduate students were all more likely to detect ED symptoms among White women, compared with women from other ethnic and racial groups (Gordon, Perez, & Joiner, 2002). These findings suggest that cultural stereotypes surrounding the conceptualization and presentation of EDs impact perceptions of vulnerability to these conditions.

In addition to these challenges, members of South Asian communities face unique barriers when seeking ED treatment. For example, one qualitative study conducted with a community-based sample of South Asian individuals in the United Kingdom identified three key barriers to ED treatment-seeking: a lack of fundamental knowledge about EDs and associated poor health outcomes, stigma concerning mental health and EDs among the South Asian community, and concerns about confidentiality when seeking care (Wales, Brewin, Raghavan, &

Arcelus, 2017). These findings are similar to those of another qualitative study in the United Kingdom, in which a sample of treatment-seeking South Asian women with EDs noted that their parents initially refused to acknowledge the presence and seriousness of their ED, and only felt comfortable seeking professional help once it became apparent that their daughters' physical health was compromised (Hoque, 2011). These findings provide further evidence that both EDs and mental health are highly stigmatized within this community.

Furthermore, researchers warn against falsely assuming that low rates of ED treatment-seeking amongst South Asians are indicative of either low rates of maladaptive eating behaviors, or high rates of body satisfaction amongst this group (Dolan, Lacey, & Evans, 1990; Kennedy et al., 2004). Instead, Kennedy and colleagues (2004) propose that this group's lower rate of treatment-seeking could be attributed to alternative explanations, such as differing definitions of maladaptive eating patterns and perceived stigma regarding psychological help-seeking. Thus, it seems important to focus on South Asians to enhance understanding of the underlying mechanisms that contribute to eating psychopathology for this group, and to identify factors that might prevent appropriate treatment-seeking behaviors.

### **Eating Disorders – Rare or Common on the Indian Subcontinent?**

The first glimpse into the nature of EDs among South Asians on the Indian subcontinent came from a series of seminal case studies that sparked interest on the subject in the early 1990s. Prior to publication of these case studies, EDs were thought to be relatively rare in developing countries and were believed to affect individuals living in Westernized cultures, or in areas influenced by Western cultures, exclusively (Prince, 1985).

One of these initial case studies focused on the experience of AN among three Muslim girls, each of whom indicated that their fasting behaviors were tied to Islamic religious practices,

which is considered socially acceptable within this religious cultural group. Interestingly, these girls did not report that their behaviors were motivated by a desire for thinness (Bhadrinath, 1990). Building off these findings, another influential case study by Khandelwal and colleagues (1995) classified five young Indian women as having AN due to "...food restriction to about a quarter of their premorbid diets and weight loss of at least 25% from their premorbid weight," (pp. 136-137) accompanied by amenorrhea. However, they found no body image disturbance, no desire for thinness, no emphasis on weight and shape concerns, and no fat phobia among this sample. Collectively, these authors concluded that EDs, as based on Western diagnostic criteria, were relatively uncommon in India. Rather, patients manifested atypical presentations of EDs devoid of most risk factors identified in Western populations, suggesting that South Asians might manifest different manifestations of eating pathology undetectable by Western-oriented diagnostic tools and criteria (Bhadrinath, 1990; Khandelwal, Sharan, & Saxena, 1995).

Although these case studies had a great impact on the direction of ED research within the Indian subcontinent, other contemporary reports yielded somewhat different results. For instance, other clinicians have found both fat and weight phobia to be relevant for South Asian adolescents (Misquitta, 2001; Perera, Wickramasinghe, Wanigasinghe, & Perera, 2002). However, because much of this early research was based on case studies of AN, rather than population-based epidemiological studies, it is difficult to determine both the occurrence and variability in symptom presentation of AN, as well as all EDs, among South Asians living on the subcontinent.

Despite a paucity of epidemiological data, recent research has demonstrated that the prevalence of EDs is rising in India and Pakistan (Thomas, Lee, & Becker, 2016). For instance, in a recent survey of South Indian psychiatrists, 67% reported seeing a patient with an ED in the

last year (i.e., AN, BN, or ED not otherwise specified), suggesting that contrary to prior research, EDs are not rare in urban India (Chandra, Abbas, & Palmer, 2012). Although many have attributed this rise to trends associated with increasing urbanization, industrialization, and the uptake of Western norms and media among South Asian society (Mumford, Whitehouse, & Choudry, 1992), previously reported low rates of EDs among South Asians might be due to multiple factors. Some of these include: (1) methodological issues in ED assessment (Choudry & Mumford, 1992; King & Bhugra, 1989; Nasser, 1998), (2) the use of Western diagnostic criteria that are not entirely relevant to South Asians (Cummins et al., 2005; Mumford, 1993; Nasser, 1986), and (3) an absence of an increased pressure to be thin (Bhadrinath, 1990; Khandelwal et al., 1995). Each of these concepts will be discussed in greater detail in later sections of this literature review.

However, given the perceived rarity of threshold EDs in India, many patients presenting with symptoms of these conditions, especially AN, do not receive treatment at earlier stages of their disorder due to misdiagnoses (Pani, Santa, & Biswas, 2015; Perera et al., 2002). EDs might not be considered at intake by psychiatrists and other health care professionals working in India, given preconceived notions concerning the relative rarity of these conditions within this culture, and the belief that Indian women are less concerned with thinness. This is potentially dangerous considering that research has shown that early intervention is key to successful treatment outcomes (Le Grange & Loeb, 2007). As such, research investigating EDs amongst South Asians, both on and outside of the subcontinent, would be helpful in minimizing this gap in knowledge about South Asians' perceptions and beliefs concerning the relevance and existence of EDs amongst this underserved population.

### **Methodological Issues in the Assessment of Eating Disorders among South Asians**

### *Western Eating Disorder Measures*

As noted above, the relative lack of understanding regarding the presentation and perceptions of EDs amongst South Asians is due in large part to methodological and conceptual issues involving the assessment, definition, and conceptualization of EDs in Westernized society (Khandelwal et al., 1995; King & Bhugra, 1989; Sue et al., 2012). Most studies assessing EDs among South Asians have used well-known measures that were normed and validated with White, Westernized samples, such as the Eating Attitudes Test (EAT-40, EAT-26; Garner & Garfinkel, 1979; Garner et al., 1982), the Eating Disorders Inventory (EDI; Garner, Olmstead, & Polivy, 1983), and the Bulimic Investigatory Test, Edinburgh (BITE; Henderson & Freeman, 1987). Although these instruments are useful in facilitating comparability of effects across different samples, findings from studies which have used them should be interpreted with caution. Evidence suggests that they might be more sensitive to detecting pathology among White women, compared with individuals from other ethnic and racial backgrounds (Wildes, Emery, & Simons, 2001).

Two studies have found support for the cross-cultural validity of the EAT-26 in samples of British South Asian adolescents (Mumford, Whitehouse, & Platts, 1991; Mumford et al., 1992). However, the authors of these studies noted that they used the standard cutoff score for the EAT as recommended by Garner and colleagues (1982) because no cutoff was available for South Asians. As such, some individuals might have been misclassified due to cultural issues affecting the instrument's validity. In addition, this measure in its current form does not account for variations in cultural practices, customs, and ideals, and as such, might not be sensitive enough to detect subtle differences in the nature, presentation, and symptomatology of EDs among South Asians (Mumford, 1993). Further understanding of specific components of the



presentation and conceptualization of these conditions within this particular cultural group is needed to refine measurement tools.

### *Different Symptom Manifestations*

Although EDs affect individuals across all racial and cultural stratifications (Cheng et al., 2019), symptoms might manifest differently in distinct groups (Mumford, 1993; Nasser, 1986). Specifically, South Asians are more likely than White individuals to report somatic, rather than psychological, ED symptoms (Anand & Cochrane, 2005; Ting & Hwang, 2007). This is one potential reason ED instruments normed in primarily White, Western groups might be less valid or relevant for South Asians (Choudry & Mumford, 1992; Mumford, 1993; Nasser, 1986).

For instance, in a sample of treatment-seeking South Asian adolescents in the United Kingdom, Tareen and colleagues (2005) found that although their patients exhibited many typical AN symptoms, such as loss of appetite, they did not endorse fat phobia or extreme weight preoccupation. As such, the authors concluded that South Asian adolescents might present with a “non-fat phobic” form of AN. This “atypical” form of AN might not be detected by either health practitioners untrained in cultural variations in symptom presentation, or by ED measures that do not assess this type of AN (Tareen, Hodes, & Rangel, 2005). Further, there might be other important ED symptoms in South Asians not currently captured by existing measures (Mumford, 1993; Mumford et al., 1992). Qualitative research could help clarify this issue.

### *Issues with Translation*

It is also potentially problematic that the EAT, EDI, and BITE have been administered to South Asian samples in English. In India, most individuals who speak English are highly educated and come from relatively wealthy backgrounds; this sampling bias likely limits the generalizability of findings (Balhara, Mathur, & Kataria, 2012; Balhara, Yadav, Arya, Mathur, &

Kataria, 2012; Pengpid, Peltzer, & Ahsan, 2015). On the other hand, translation poses its own challenges. Specifically, simply translating a measure from its original development language without also taking steps to adapt it culturally to maintain conceptual integrity can alter psychometric properties, such as content validity (Beaton, Bombardier, Guillemin, & Ferraz, 2000). Consequently, the resulting instrument might assess something other than what the original was designed to measure, contributing to misleading conclusions about cultural differences (Hilton & Skrutkowski, 2002; Sperber, Devellis, & Boehlecke, 1994). As such, the translated measure could be vulnerable to both linguistic and semantic misinterpretation (King & Bhugra, 1989; Nasser, 1997). Then again, although it is helpful that the EAT has been translated into different languages and has been administered in Arabic (Nasser, 1986), Hindi (King & Bhugra, 1989), and Urdu (Choudry & Mumford, 1992), the fact that this measure is available in these languages does not necessarily mean it is culturally appropriate for South Asians.

For example, Choudry and Mumford (1992) noted that although they were able to successfully translate the EAT from English to Urdu, there were some concepts that were frequently misunderstood, such as items asking about calories. Bhugra and King (1988) discovered a similar problem in their sample of Indian schoolgirls. Specifically they found that even after translating the questionnaire into the local language, certain items on the EAT that asked participants to rate whether “food controls [their] life,” or determine whether they “enjoy[ed] trying new rich foods,” had different implications in that cultural setting. In general, given the variability in EAT scores across different cultural and linguistically-diverse groups, ED researchers are cautioned against assuming uniformity in the interpretation of the EAT across different populations (Nasser, 1998). Instead, researchers and clinicians are advised to adapt these measures to include an index of culture-specific norms and differing thresholds to detect

new clinical cases (Boyadijeva & Steinhausen, 1996; Steinhausen, 1984; Nasser, 1998).

Qualitative research can be especially helpful in identifying previously unrecognized symptoms and culture-specific norms that could be especially relevant for this group and inform the development of culturally-sensitive ED measures.

### **Relevance of Body Image and Eating Disorder-Related Constructs among South Asians**

Although researchers have identified a multitude of biological and sociocultural ED risk factors in Western populations (Striegel-Moore & Bulik, 2007), it is unclear whether these same constructs are equally relevant to these conditions in South Asians. To begin addressing this issue, this section reviews the literature regarding the relevance of ED-related constructs, such as the internalization of the thin ideal, factors related to obesity, and body dissatisfaction, for South Asian communities.

#### *Value of Thinness*

There has been much debate regarding the value of thinness within South Asian culture. Some have argued that South Asians were protected from the development of EDs, because the traditional female ideal was portrayed as voluptuous and emphasized certain body features, such as the ankles, neck, and wrists, rather than weight-centric areas focused on in the West, such as the stomach and hips (Khandelwal & Saxena, 1990; Littlewood, 1995; Nasser, 1988). However, others argue that South Asian culture emphasizes thinness in a manner similar to Western cultures, although a broader range of weights and body sizes are more acceptable in India (Gandhi, Appaya, & Machado, 1991; Perera et al., 2002). This latter view is supported by consistent findings demonstrating that a majority of South Asian women report body dissatisfaction, concerns about being overweight, and engaging in dieting behaviors as a means of reducing anxiety about securing suitable marriage prospects, and thus, attaining both

economic and social security (Hoque, 2011; Suhail & Nisa, 2002). Therefore, preliminary evidence seems to suggest that thinness holds at least some social value for South Asian women.

**Internalization of the thin ideal.** Interestingly, although the internalization of the thin ideal is considered a robust risk factor for ED pathology amongst White women (Striegel-Moore & Bulik, 2007), there are conflicting findings regarding the relevance of this construct for South Asians. In one study assessing the relations among thin-ideal internalization, body dissatisfaction, and gender among a sample of Sri Lankan adolescents, girls reported *lower* levels of thin-ideal internalization relative to their male counterparts (Omori, Yamazaki, Aizawa, & de Zoysa, 2016). Given that these findings were highly inconsistent with findings in the West, the authors speculated that these observed differences could be attributed to characteristics unique to Sri Lankan culture (Omori et al., 2016). Thus, although the thin ideal was a relevant construct for male adolescents, the same cannot be said for female adolescents, suggesting that there might be gendered differences in the importance of the thin ideal amongst Sri Lankan individuals.

In two studies conducted with South Asian women outside of the Indian subcontinent, specifically Canada and the United States, researchers found that culturally-salient factors, such as a desire to meet parental expectations or cognitive dissonance resulting from occupying two different cultures, were more strongly related to eating pathology, than was the pursuit of thinness (Mustafa, 2013; Reddy & Crowther, 2007). These results suggest that unlike their White counterparts, South Asian women living in Westernized countries might have distinct ED risk factors.

Moreover, various studies have noted that many South Asian adolescents (both those living on the Indian subcontinent and those in the diaspora) with ED symptoms often express either no desire to be thin or no desire to lose weight (Bhadrinath, 1990; Bhugra & Bhui, 2003;

Khandelwal et al., 1995; Tareen et al., 2005). Considering the conflicting findings presented in the aforementioned studies, the relevance of this thin ideal to disordered eating in South Asians remains unclear. It is possible that an alternative appearance-related ideal is more relevant for this group, one that emphasizes a different facet of the body or set of body areas rather than thinness, per se. However, more research, including qualitative investigation, is necessary to address these issues.

### *Colorism*

Although there has been much debate concerning the value of thinness within South Asian culture, there is little controversy about the value of *lighter skin* amongst this group. Colorism, or the preference for lighter-skinned tones resulting in the stigmatization of dark skin tones within a particular racial group, is not a new phenomenon among South Asians (Russell-Cole, Wilson, & Hall, 2013). Differences in skin color are magnified in settings in which an individual of color resides in a country in which she is an ethnic minority. In fact, the relation between colorism and ED pathology is well-documented amongst South Asian immigrants (Bhagwat, 2012; Furnham & Patel, 1994; Sahay & Piran, 1997).

In a study comparing South Asian-Canadian women with European-Canadian women, Sahay and Piran (1997) found that, although South Asian women overall reported lower body dissatisfaction than their European counterparts, darker-skinned South Asian women reported both the highest rates of body dissatisfaction, and the strongest desire for lighter skin. Moreover, darker-skinned participants' desire for lighter skin was positively related to body dissatisfaction. These findings regarding the link between colorism and maladaptive eating behaviors have been confirmed in other studies (Bhagwat, 2012; Furnham & Patel, 1994), highlighting the need to

study South Asians' perceptions surrounding skin color as a potential factor in the development and maintenance of EDs for this population.

### *Obesity Epidemic and the Rise in Body Dissatisfaction*

With the rise in development, industrialization, and globalization over the last few decades, India is now experiencing simultaneous obesity and malnutrition epidemics (Subramanian & Smith, 2006). In light of this relatively recent obesity epidemic, a pervasive fear of fatness, body size discrimination (e.g., weight stigma), and accompanying body dissatisfaction now exist among both Indian adolescents and adults (Agrawal, Gupta, Mishra, & Agrawal, 2015; Ambwani, Gleaves, & Perez, 2015; Chugh & Puri, 2001; De & Chakraborty, 2015).

### *Different Forms of Appearance-Related Stigma*

**Weight stigma.** Researchers have found that, compared to Indian women with overweight, Indian women with morbid obesity were 12 times more likely to report body dissatisfaction, and nine times more likely to report stigma and discrimination based on their body size. Indian women with obesity were three times more likely to report body dissatisfaction and three times more likely to report discrimination compared to their peers with overweight (Agrawal et al., 2015). This negative reaction to obesity, in the forms of body size discrimination and fat shaming, is also evident among South Asian immigrants. In a cross-national study comparing Indian female college students living in India and European American female college students living in the United States on their respective weight-related attitudes, Ambwani and colleagues (2015) found that, whereas White individuals feared weight gain the most, Indian women disliked overweight in *other* individuals the most (i.e., anti-fat attitudes). Thus, additional study of the effects of weight stigma and its internalization might enhance

understanding of how these feelings contribute to eating pathology across the weight spectrum in this group.

**Social stigma.** Many studies have found evidence implicating the social stigma surrounding obesity in India as a contributor to eating pathology among both adolescents and adults. For adolescents in particular, this stigma seems especially dangerous for individuals with overweight and obesity. For example, in one study assessing eating attitudes among Indian adolescents, Stigler and colleagues (2011) found that all adolescents, regardless of their weight status, felt that controlling their weight was important, and youth with overweight reported the highest body dissatisfaction. Furthermore, adolescents with overweight and obesity were more likely to attempt to control their weight, using both healthy and unhealthy strategies, compared to their peers with normal weight (Stigler et al., 2011). Similarly, Mallick and colleagues (2017) found that among a large sample of female Bengali adolescents, those who endorsed maladaptive eating attitudes had significantly higher body mass indices (BMIs) and body fat percentages relative to their counterparts. Another study found that Indian adolescents' satisfaction with their bodies and appearance increased as their weight decreased, and 76.6% of adolescents with obesity engaged in dieting, compared with 38% of participants with normal weights and 14% of participants with underweight (Chugh & Puri, 2001). Similarly, Ashok and Karunanidhi (2015) found that female college students with relatively high BMIs and body fat percentages engaged in more restrictive eating behaviors compared with students at normal or underweight statuses. Interpreting these findings collectively, research indicates that South Asian individuals with overweight or obesity might be at greater risk of engaging in unhealthy weight control behaviors, developing body dissatisfaction, and endorsing ED behaviors, compared to their peers with underweight and normal weight.

### *Body Dissatisfaction*

Rising obesity rates are associated with increases in body dissatisfaction among the Indian population (Gupta & Kapur, 2017), which is alarming considering that body dissatisfaction is a prominent risk factor for the development of serious ED psychopathology in other populations (Striegel-Moore & Bulik, 2007). Indeed, various studies have shown that South Asian individuals, regardless of their weight status, experience body dissatisfaction (Chugh & Puri, 2001; De & Chakraborty, 2015; Raberg, Kumar, Holmboe-Ottesen, & Wandel, 2009), and, within this group, body dissatisfaction is related to disordered eating behaviors (Balhara, Mathur, et al., 2012). Among Indian college students within a normal weight range, body dissatisfaction is especially high, with one study reporting that 80% of their sample of female college students living on the Indian subcontinent felt dissatisfied with their bodies (De & Chakraborty, 2015). Relatedly, use of weight management strategies is high amongst Indian college women across the weight spectrum, with one study finding that 59.2% reported using at least one method of weight control (i.e., dieting, restricting oil intake, skipping a meal, restricting eating in between meals, exercise, binge eating) (Srinivas, Ravi, Prashantha, & Prakash, 2017). Thus, it seems that South Asian college women across the weight spectrum are both preoccupied with their weight, and engage in risky practices as a means of controlling it.

Additionally, a few studies have found a link between individuals' misclassification of their weight status and body dissatisfaction. For instance, one study of Pakistani college women found that they were very likely to misclassify their weight status, with nearly a quarter of those at a normal weight considering themselves overweight (Sirang et al., 2013). Similarly, two other studies conducted with female Indian healthcare students found that individuals' self-determined ideal weight was more strongly associated with body dissatisfaction than was their actual weight



status (Balhara, Mathur, et al., 2012; Balhara, Yadav, et al., 2012). Moreover, weight misperception can be especially problematic for South Asian adolescents, with one study finding that male and female adolescents who were normal weight, but viewed themselves as overweight or obese, were three times more likely to attempt weight loss relative to individuals with normal weight who perceived their weight accurately (Swaminathan, Selvam, Pauline, & Vaz, 2013). Thus, it appears that South Asians who have difficulty accurately assessing their weight and shape may also be vulnerable to maladaptive eating behaviors.

Overall, the social context surrounding the rise in obesity rates, body size discrimination, social stigma surrounding overweight/obesity, and body dissatisfaction, provides an important framework for conceptualizing the attitudes, behaviors, and concerns that serve as potential contributors to maladaptive eating behaviors among South Asians. In the next section, an additional component of this framework, Western media exposure, is discussed in more detail.

#### *Bringing the West to Bollywood: The Influence of the Media*

Similar to findings from the West (Grabe, Ward, & Hyde, 2008; Stice, Schupak-Neuberg, Shaw, & Stein, 1994), researchers have found that the media's promotion of thinness and weight consciousness, especially for women, contributes to eating pathology and body image concerns among South Asians. Although South Asian society has traditionally valued a more voluptuous, fuller figure as the feminine ideal (Littlewood, 1995; Nasser, 1988), a marked shift in these values is reflected by Bollywood's increasing emphasis on thinner, lighter-skinned actresses wearing relatively revealing Western clothing (Iyer & Haslam, 2006).

In turn, the correlates of exposure to and internalization of these media messages seem to be eerily similar to phenomena documented in the West. For example, Shroff and Thompson (2004) found that internalization of media images was directly related to restriction and a drive

for thinness for Indian women. Similarly, another study found that exposure to Western culture and body dissatisfaction, not BMI, were associated with negative eating attitudes in a sample of middle- and upper-class Pakistani women (Suhail & Nisa, 2002). As such, these authors determined that the cultural transmission of Western ideals via advertisements and television programming significantly contributed to ED pathology, feelings of fatness, and unrealistic body perceptions for women in their sample (Suhail & Nisa, 2002). A review of available data regarding the impact of Westernization on ED pathology in this group is explored in the next section.

### **Westernization and Acculturation**

#### *Westernization*

Although it was previously thought that EDs were “culturally-bound syndromes” (Prince, 1985), many studying these conditions in culturally and racially diverse samples have operated from the standpoint that EDs are rather “*culture-change syndromes.*” These “culture-change syndromes” occur when a society undergoes economic, social, and cultural changes in the forms of urbanization, industrialization, globalization, and Westernization (DiNicola, 1985, 1990). This viewpoint emphasizes that once a society starts to adopt Western ideals, values, and practices, individuals become more susceptible to ED psychopathology.

In general, there are mixed findings concerning the impact of Westernization on the development of psychological distress among South Asians. In their extensive review of the psychological literature on South Asian Americans, Inman and colleagues (2014) found that although some studies have demonstrated that greater adaptation and assimilation with Western ideals yielded healthier outcomes for South Asians, others have found that South Asians with a preference for their own ethnic culture experienced acculturative stress when trying to integrate

into new host countries. Thus, in terms of the broader mental health literature, the impact of Westernization on the psychological health of South Asian Americans remains unclear.

The potential role of Westernization in the onset of EDs amongst South Asians is similarly murky. Although some have argued that fear of fatness and economic and public health changes in the West were instrumental in the rise in EDs on the Indian subcontinent (Littlewood, 1995), others have argued that fear of fatness, emphasis on thinness, and dieting behaviors are not necessary to develop an ED (Mumford, et al., 1992; Wildes et al., 2001). Furthermore, some studies have found support for the contributing role of Westernization to the overall rise in eating pathology in South Asian samples (Mumford & Choudry, 2000; Mumford et al., 1992; Nasser, 1997; Suhail & Nisa, 2002), whereas others have found links between traditional South Asian cultural values and disordered eating attitudes (Mumford et al., 1991).

One possible explanation for these mixed findings might be that “Westernization” as a construct has been defined, operationalized, and measured in a multitude of ways. Some examples of these variations include defining Westernization in terms of English-speaking capabilities, eating Western foods (Mumford et al., 1992) viewing Western media (Saghir & Hyland, 2017; Shroff & Thompson, 2004; Suhail & Nisa, 2002), wearing Westernized clothing, and more. Furthermore, only a minority of researchers have utilized validated and reliable measures of Westernization (i.e., Shroff & Thompson, 2004), as most opted to develop their own brief questionnaires for the purposes of their respective studies (i.e., Mumford et al., 1992; Furnham & Patel, 1994). Thus, although it is difficult to measure the impact that Westernization has had on the incidence, prevalence, and development of EDs among South Asian populations, it seems to be a widely held belief that the relative rise in EDs in India over the past few decades

has coincided with the dissemination and popularization of Western media and television (Iyer & Haslam, 2006).

### *Acculturation*

Acculturation is one index of the Westernization process, which is of great interest to multicultural researchers. Acculturation is defined as the process of adjustment to, and the adoption of, the values, norms, and practices of a new culture that occurs after an individual encounters a culture other than his or her own (Berry, Trimble, & Olmedo, 1986). Although much of the ED literature on immigrant populations and racially diverse samples has focused on assessing the potential influence of acculturation on ED psychopathology in these groups, Wildes, Emery, and Simons (2001) conducted a meta-analysis of studies addressing this topic and found no substantial evidence for a relation between level of acculturation and ED symptomatology. These authors also found methodological differences in the measurement and operationalization of acculturation, such that some researchers used a variety of terms, including "acculturation," "assimilation," and "ethnic orientation" synonymously, potentially confounding results (Wildes et al., 2001).

In another comprehensive review of the role of acculturation in EDs among Asians, Cummins, Simmons, and Zane (2005) criticized studies for focusing more on distal (e.g., ethnic group, country of origin, primary language) rather than proximal variables (e.g., self-construal, eating habits, coping styles). Rather than relying on distal factors, or even the level of acculturation that a particular individual has undergone, they proposed that these proximal variables might be influenced by specific cultural factors, such as placing a high value on academic achievement. Thus, a deeper understanding of specific, proximal variables might

provide more insight into which features of a particular culture contribute to eating pathology (Cummins et al., 2005).

In sum, although the acculturative process might contribute to eating pathology for South Asians abroad, research is needed to identify more proximal culturally-influenced constructs, behaviors, and psychological processes (e.g., skin tone preferences), to enhance understanding of factors potentially contributing to ED pathology within this group. Thus, qualitative research that aims to clarify the ways in which South Asians conceptualize EDs seem to be of particular relevance.

### **Unique Cultural Constructs that Contribute to Eating Disorders for South Asians**

#### *Cultural Conflict*

One proximal variable identified as particularly relevant to South Asians by researchers in both the mental health and ED literature is internalization of cultural conflict (Inman, Ladany, Constantine, & Morano, 2001; Reddy & Crowther, 2007). Cultural conflict refers to the psychological tension that South Asian immigrants experience when trying to negotiate conflicting values that result from inhabiting an independent, Westernized culture while simultaneously trying to maintain more traditional, interdependent South Asian values (Inman et al., 2001). This can be especially problematic considering that these value systems are often discordant (Inman et al., 2001; Inman, 2006).

There is evidence suggesting that conflict between conservative South Asian values and relatively liberal Western values is linked to maladaptive eating behaviors for South Asians living in the diaspora (Bryant-Waugh & Lask, 1991; Javier, 2017; Mustafa, 2013; Reddy & Crowther, 2007). Specifically, a few studies have demonstrated that conflict between a parent and child concerning traditional South Asian values, known as interfamilial conflict, is an

important cultural correlate of ED psychopathology among South Asians living in Britain (Bryant-Waugh & Lask, 1991). Among South Asian adolescents, disordered eating attitudes were positively associated with feelings of resentment towards their parents about lack of choice regarding their romantic partner (Furnham & Patel, 1994). Similarly, in a small qualitative study, Mustafa (2013) found that cultural conflict, specifically a need to please parents and adhere to traditional cultural and familial expectations, was associated with ED pathology in a clinical sample of South Asian women.

Relatedly, Mumford and colleagues (1991) found that for British South Asian adolescents, more negative eating attitudes and body dissatisfaction were associated with traditional South Asian cultural orientations. This suggests that, for some, ED pathology might be associated with cultural and familial difficulties related to growing up as a cultural outsider in the United Kingdom. Similarly, Furnham and Patel (1994) noted that South Asians who endorsed negative eating attitudes felt like outsiders within British society and desired a different skin color. Taken together, these findings betray an underlying tension, or cultural conflict, between adherence to South Asian cultural values and fitting into the Western cultural landscape.

Lastly, cultural conflict between the values associated with collectivist, Eastern cultures and individualistic, Western cultures is linked to body dissatisfaction for South Asian American women (Reddy & Crowther, 2007). South Asian women living in the United States must confront and adapt to a bicultural identity in which they are expected to adhere to traditional gender and cultural norms, while also trying to maintain a sense of independence promoted by American culture (Inman et al., 2001; Tummala-Narra, 2013). For some individuals, these conflicting values appear to result in tension that can manifest itself in ED symptomatology and

related risk factors, including body dissatisfaction. Overall, it seems that cultural conflicts between discordant values are associated with eating pathology for South Asians.

#### *Parental Control and Perceived Overprotectiveness*

Parenting behaviors are also strongly influenced by cultural norms (Maynard & Harding, 2010; Raj & Raval, 2013). The optimal role of parents in the lives of their children has been found to differ between White and South Asian cultural groups (Ali & Frederickson, 2011; Maiter & George, 2003). Moreover, many studies have found a positive association between perceptions of parental control and overprotectiveness and ED symptomatology among South Asian adolescents. For example, one study demonstrated that relative to their White peers, South Asian girls living in the United Kingdom viewed their mothers as more controlling and uncaring. In addition, these maternal characteristics were related to elevated body dissatisfaction and eating pathology for this group (Ahmad, Waller, & Verduyn, 1994). In fact, perceived parental control played such a strong role in South Asian girls' body dissatisfaction that when this variable was removed from the statistical model, South Asian adolescents were actually *more* satisfied with their bodies relative to their White counterparts (Ahmad et al., 1994). Furthermore, Bhugra and Bhui (2003) found that girls at high-risk of developing an ED (assessed via a diagnostic clinical interview) reported feeling infantilized and expressed a desire for more independence from their parents. These results are consistent with those of other research which has found that second-generation South Asian girls living in Britain report higher levels of parental overprotectiveness compared with their White peers (Furnham & Adam-Saib, 2001).

These negative feelings about parental control appear to be maintained into early adulthood. For instance, one study found that Pakistani college students in the United Kingdom exhibited the highest levels of maladaptive eating attitudes, parental protection, and parental

conflict compared with both their British White counterparts and native Pakistanis living in Pakistan (Mujtaba & Furnham, 2001). Given that the Pakistani students living in a Westernized, predominantly White society, reported greater conflicts with their parents relative to Pakistani students living in Pakistan, it could be that internalized cultural conflict contributes to maladaptive eating patterns in this group, although this relation was not explicitly examined in this study.

Lastly, it is important to note that, although feeling overly controlled by parents can contribute to eating pathology for South Asians, feeling under-supported by parents also appears harmful for this group. For example, Chang, Perera, and Kupfermann (2014) found that a perceived lack of family support was correlated with eating disturbances for both male and female South Asian American college students. More specifically, lack of family support was the strongest correlate of all eating disturbances for females. Thus, these findings provide some insight into how complications in relationships between South Asian parents and their children can be associated with eating pathology.

#### *Model Minority Stereotype and Academic Achievement Pressures*

Pressures associated with upholding the "model minority" stereotype are linked to greater levels of both global psychological distress as well as maladaptive eating behaviors in South Asians. Sociologist William Peterson first coined the term "model minority" in 1966 to label Asians, including South Asians, living in the United States as optimal citizens of society. This label was based on the widely held belief that Asians are more likely to achieve socioeconomic, academic, and social success, relative to other ethnic minority groups (Chou, 2008; Varma, 2006). At the heart of this stereotype is the assumption that South Asian Americans' relative prosperity in terms of socioeconomic and social standing within the United States is attributable



to their cultural background, which generally emphasizes a respect for authority, obedience and passivity, educational achievement, and diligence.

Although the model minority stereotype is generally considered to reflect a positive view of Asian Americans, it is important to acknowledge that the psychological stressors associated with the expectations surrounding this stereotype can lead to poor mental health outcomes for this group, including South Asians. For example, one of many reasons why South Asians have been understudied in the mental health literature is due, in part, to the misunderstanding that positive qualities associated with the model minority stereotype would protect this group from developing psychopathology (Inman et al., 2014). However, data suggest this is not the case. For example, one study assessing belief in the model minority stereotype among Asian Americans found that high endorsement of this stereotype was linked to greater psychological distress, somatic complaints, and negative attitudes towards help-seeking (Gupta et al., 2011). Thus, if internalizations of the model minority stereotype are related to psychological distress for South Asians, it makes sense that this stereotype could also influence the presentation of other psychological issues, including EDs.

Data support the model minority tenet that South Asian culture places a great emphasis on academic achievement (Inman et al., 2014; Varma, 2006). However, it is important to acknowledge that the psychological pressures associated with high academic expectations can also be linked to eating pathology. Specifically, Chang, Perera, and Kupermann (2014) found that South Asian women were more likely than their male counterparts to base their sense of self-worth on their perception of others' approval, how attractive they perceived themselves to be, and their academic achievement. Although these authors did not assess for explicit endorsements of the model minority stereotype, the influence of this stereotype, coupled with cultural

expectations surrounding academic achievement, could contribute to eating pathology for female South Asian American college students. Thus, investigating the relevance of the model minority stereotype to eating behaviors for this group is an important next step towards understanding how eating pathology manifests amongst South Asians.

### *Racial Teasing*

In addition to the model minority myth, it may be helpful to study how other stereotypes and experiences of marginalization may contribute to eating pathology for this group. Although some have found that teasing is associated with restriction and the drive for thinness in Indian adolescents (Shroff & Thompson, 2004), one study specifically identified *racial teasing*, rather than acculturation and ethnic identification, as the strongest correlate of maladaptive eating behaviors and body dissatisfaction in South Asian American women (Iyer & Haslam, 2003). In the aforementioned study, “racial teasing” was defined as “...the perceived frequency and impact of teasing on the basis of one’s race or ethnicity,” including name-calling, behavior-related teasing, stereotyping, appearance-related teasing, and social exclusion (Iyer & Haslam, 2003, p.144). In fact, both racial discrimination, and identifying as an ethnic minority, are significant psychological stressors for first- and second-generation South Asian Americans (Kaduvettoor-Davidson & Inman, 2013; Tummala-Narra, Inman, & Ettigi, 2011). Thus, racial teasing as a unique index of discrimination and racial prejudice for South Asians living in the United States might be an important factor to consider in relation to EDs among this group.

### **The Current Study**

The current study aimed to clarify the ways in which South Asian women living in the United States understand, conceptualize, and discuss their experience with body image and EDs. Specifically, this research attempted to answer the following questions: (1) how do South Asian

women living in the United States understand and discuss body image and ED concerns and (2) what are barriers and facilitators to ED treatment for this population? To achieve these aims, this study utilized a qualitative design involving moderated focus group interviews to assess participants' experiences and understanding of: (1) body image and EDs (i.e., their definitions of these conditions), (2) potential protective and risk factors of eating pathology for this group, and (3) barriers and facilitators to ED treatment for this population. Given that the current study was exploratory in its scope, no *a priori* hypotheses were established; instead, conclusions and interpretations from these interviews are data-driven (Braun & Clarke, 2006; Elo & Kyngas, 2008). These data can provide a foundational understanding of how South Asian women living in the United States discuss these conditions. This information could help guide health professionals in the assessment, prevention, and treatment of disordered eating within this community.

## **Methods**

### *Participants*

A convenience sample of South Asian American females was recruited via outreach to Virginia Commonwealth University's (VCU's) student population. At the time of recruitment, 12.97% of VCU students identified as Asian (Virginia Commonwealth University, 2018). Eligibility criteria for this study included the following: individual must identify as female, be  $\geq$  18 years old, have no children, be of South Asian descent (i.e., at least one parent or grandparent was born on the Indian subcontinent), and must have lived in the United States for at least three years. This latter criterion was determined to be an optimal point that gave an individual enough time to become familiarized with American culture. Considering the aims of the current investigation, coupled with past documentation of low research participation and retention rates

amongst Asians in general (George, Duran, & Norris, 2014), and low ED treatment-seeking rates amongst South Asians specifically (Fountain & Hicks, 2010; Kennedy et al., 2004), this study was not conducted in a clinical setting. Rather, participants were recruited through a variety of methods, including flyers (see Appendix A), dissemination via email listservs (e.g., the TelegRAM), department postings, and emails to relevant cultural and student groups (e.g., Tiranga - Indian Nationals at VCU, Indian Student Association, Bangladeshi Student Organization at VCU, Nepalese Student Association at VCU, Pakistani Students Association, Muslim Students Association), research postings on SONA, and referrals by word-of-mouth/snowballing techniques. Informed consent was obtained in-person prior to formal participation in the study and all procedures and study materials were reviewed and approved by the Institutional Review Board (IRB) at VCU.

### *Study Design*

A qualitative design was employed. In general, qualitative research allows researchers to gain an intimate understanding of a topic. All qualitative research designs share three fundamental strengths: (1) an ability to elicit exploration and discovery, (2) gain breadth and context, and (3) provide a summary and interpretation of the underlying mechanisms that can help explain both similarities and variations across a series of participant experiences (Morgan, 1998a). Qualitative designs can be utilized to both identify and mend gaps in the literature by summarizing a particular group's psychological experience with the topic at hand. Unlike quantitative research designs, which require pre-determined options that limit participants' responses, qualitative methods allow participants to express their viewpoints unconstrained by the researcher and, as such, can capture a more accurate representation of a participant's understanding of their experience (Rumsey & Marks, 2004). Overall, the primary advantage of

qualitative, relative to quantitative, designs, is that they allow researchers to gain insight and elicit exploration amongst an under-researched community and/or area of interest. Qualitative investigations are relatively less generalizable due to their small sample sizes, and require significant resources (i.e., time and money) compared with quantitative investigations (Braun & Clarke, 2006; Hughes & DuMont, 1993; Morgan, 1998b). Nonetheless, a qualitative approach was deemed particularly appropriate for the current study, given the lack of knowledge about the etiology and manifestation of EDs amongst South Asians living in the United States.

Focus groups were selected as the specific qualitative method for the current study for several reasons. Focus groups are moderated group interviews that elicit data from a representative sample from the population of interest in order to enhance understanding of its particular needs. Investigators using this approach bear witness to conversations amongst a group of participants on a particular topic and are tasked with summarizing their collective experiences in hopes of enhancing understanding, both among the broader research community, as well as among the population of interest. The social environment of a focus group is central to the success of this method in that it allows researchers to observe the extent to which certain cultural knowledge is transmitted across a group, and highlights variance in individuals' experience of such knowledge (Hughes & DuMont, 1993). Focus groups are particularly appropriate for facilitating culturally-sensitive research that aims to capture and represent participants' lived experiences using their own language, behaviors, and social cues (Hughes & DuMont, 1993).

### *Procedure*

Recruitment materials directed interested individuals to contact the researcher for participation in the current trial. Each participant was compensated with \$15 in cash, and if eligible, also received 1.5 SONA research credits for her time. Thus, a participant had the

opportunity to earn both \$15 cash and 1.5 SONA credits as a result of their participation in the current study. Participants were scheduled using an online, anonymous polling service (i.e., Doodle). A total of seven focus groups were conducted, each consisting of 6-10 participants for a grand total of  $N=54$  participants. Each focus group was moderated by the principal investigator, spanned approximately 90 minutes, and was audio recorded. A process observer trained in qualitative methods, and who identified as a South Asian woman, observed a majority of the focus groups (5/7) and took relevant notes. The principal investigator followed a similar protocol for each focus group, regardless of whether the process observer was present, such that she asked questions according to the semi-structured interview guide developed specifically for the current study aims. Considering that videotaping might discourage honest participation and might pose a threat to anonymity, this approach was not used, due to the sensitive nature of the topic being discussed (i.e., EDs) and the population under observation (i.e., South Asian women). To minimize discomfort and promote safety, the interviewer used self-disclosure as a tool in order to help “level the playing field,” disrupting the standard hierarchical relationship between the researcher and participants in the hopes of building rapport and creating a more comfortable environment (Dickson-Swift, James, Kippen, & Liamputtong, 2007). Further, to maintain anonymity and confidentiality throughout the interview process, participants were asked to refrain from verbalizing any identifying information; instead, they were asked to state their South Asian country of origin.

The moderator used a semi-structured interview guide to direct and facilitate group discourse (See Appendix B). This semi-structured approach was especially useful in this context, both for eliciting new ideas and perspectives on areas that remain relatively unknown (e.g., appearance-ideals amongst South Asian American women), and for facilitating comparison of

the occurrence of particular themes across groups. As such, less structured interview guides allow both the research team and participants to explore topics that are meaningful to both parties (Morgan, 1998b). In addition, the moderator employed a “funnel approach” with her directed questioning, such that she commenced with broader, more-open ended questions, then invited discussion on a few key central topics, and closed with more directed, specific questions on a particular area (Morgan, 1998b). As such, the moderator followed a trajectory that began with a broad overview and ended with a narrowed focus.

In the last ten minutes of the focus group, individuals were asked to complete a brief paper-and-pencil self-report questionnaire assessing sociodemographic characteristics (see Appendix C). These data allowed the researcher to derive descriptive statistics for the overall study sample. After each group, the audio file was immediately uploaded to a secure research server and deleted from the recording device in preparation for transcription. Further, the principal investigator and process observer met to review important ideas, compare notes, and identify preliminary themes.

### *Ethics, Trustworthiness, and Rigor*

The principal investigator took several steps to protect participants' rights to confidentiality and ensure privacy by: (1) obtaining consent, (2) asking them to refrain from stating any identifying information during the interview, and (3) using de-identified quotes in the final write-up of the codes and themes. Further, culturally-sensitive research practices encourage researchers to include participants in the research process, when possible. Member-checking serves the dual purpose of increasing the validity of the researcher's interpretations as well as ensuring that she captures participants' experiences in the way in which they intended (Creswell & Miller, 2000; Creswell & Poth, 2018). As such, the principal investigator attempted to employ

member-checking practices offering a meeting to review the penultimate codebook, themes, and interpretations with participants. In addition, she included a participant on the research coding team to peer-check the data and accompanying interpretations. This is described in more details in the Analytic Strategy section.

### *Research Team*

The data collection team consisted of the principal investigator, who facilitated each focus group, and an undergraduate research assistant who served as a process observer. The coding team consisted of three graduate research assistants (including the principal investigator), one undergraduate research assistant who volunteered to serve on the coding team after participating in the study, and one faculty member. All team members were trained in best practices in qualitative research and fulfilled requirements for ethical practice (including CITI training) prior to data analysis. All coders only reviewed de-identified transcripts. The undergraduate research assistant acted as an additional “check” on the coding team to represent the collective views of the sample.

As a means of bolstering trustworthiness and rigor, researchers are encouraged to practice reflexivity by explicitly stating their biases and any relevant experiences prior to data analysis (Creswell & Poth, 2018). As such, it is important to note that the principal investigator is a South Asian (Indian) American female in her mid-20s who initially developed this research study and semi-structured interview guide for the purposes of her master’s thesis study. This was her first venture into designing a qualitative study, for which she prepared by enrolling in a qualitative methods class. The second graduate student is a White female in her mid-20s who had prior experience with transcription and qualitative data collection during her undergraduate career. The third member is a Black female doctoral student in her early 30s. She possessed extensive



prior experience with qualitative studies, acting as a coder for another focus group study investigating differing appearance ideals in racially diverse women, and is concurrently conducting her own qualitative study with Black women. The undergraduate student team member is a senior at VCU and is currently in her early 20s. She had limited research experience prior to this appointment; however, given her involvement with the study as a participant, she provided unique expertise and valuable insight to the coding process. The last team member was a White professor in her mid-40s with extensive experience conducting body image and ED research using qualitative and quantitative methodologies with diverse populations.

#### *Data Preparation*

All focus group interviews were audio recorded and stored on a protected research drive in the principal investigator's research laboratory. Audio files were destroyed following study termination. Only study staff approved by the VCU IRB had access to the audio recordings and transcripts. Audio files underwent initial transcription by research assistants trained in ethical practices for research and qualitative methods. Finally, transcripts were reviewed for a second time (for second-data entry) by the principal investigator to check for accuracy, contextual issues (e.g., if a participant arrived late, this was marked), and provide explanations for culturally-specific, non-English words and concepts.

To bolster both the credibility of qualitative research, and the quality of interpretations made from it, researchers are encouraged to provide precise and comprehensive documentation of the data collection, analysis, and interpretation process via an audit trail (Creswell & Mitchell, 2000; Rodgers & Cowles, 1993; Wolf, 2003). As such, all materials collected during the study (i.e., consent forms, audio recordings of focus group interviews, interview transcriptions, moderator, process observer, and coding team notes) were maintained in an organized fashion

and stored in a secure folder in the principal investigator's laboratory space. All notes generated during the thematic coding analysis were stored in this folder as well.

Saturation is an important concept in qualitative research, and is defined as the subjective threshold at which all meaningful themes and ideas have been collected from a particular population of interest and/or on a particular topic of interest to the point that continuing to conduct focus groups becomes redundant, rather than informative (Krueger, 1988). The threshold for saturation is not calculated prior to conducting a qualitative design. Instead, saturation is a dynamic process determined by the principal investigator during the course of the administration of focus groups and is usually indicated when group discussions yield redundant information (Krueger, 1988). As recommended by Krueger (1988), focus groups were conducted until saturation was achieved (i.e., the point at which most, if not all, unique themes, patterns, and ideas are captured).

#### *Analytic Strategy: Thematic Analysis*

Considering that knowledge of the nature of body dissatisfaction and EDs amongst South Asian women living in the United States is limited, the principal investigator employed a qualitative descriptive approach. This method describes individuals' experience with a particular phenomenon using their own words and ideas, provides methodological and theoretical flexibility, and allows the researcher to remain data-near as a means of facilitating the emergence of important themes and concepts (Coralfi & Evans, 2016; Sandelowski, 2000; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). One of the primary advantages of qualitative descriptive approaches relative to other qualitative methodologies is that, given this approach's minimal emphasis on data interpretation, researchers' inherent biases are less influential during the data analysis process, bolstering credibility and consensus in interpretations across investigators

(Sandelowski, 2000). Overall, given the exploratory nature of this investigation, themes arising from the moderated discussions in the focus groups guided conclusions concerning the conceptualization of ED and body image concerns among South Asian American women.

Thematic analysis is a method considered particularly compatible with qualitative descriptive approaches (Braun & Clarke, 2006; Willis et al., 2016). The use of thematic analysis is common in mental health research as a means of facilitating culturally-sensitive participatory research and, “is best suited for elucidating the specific nature of a given group’s conceptualization of the phenomenon under study” (Joffe, 2012, p. 212). Thematic analytic approaches aim to identify and describe the central ideas (i.e., “themes”) that are salient for a specific group (Pistrang & Baker, 2012). Thematic analysis is considered to be the “qualitative analog of the statistical approaches of factor analysis or cluster analysis, both of which aim to describe a complex data set in terms of a number of dimensions or groupings” (Pistrang & Baker, 2012, p. 9). In contrast to other popular qualitative analyses, such as content analysis, thematic analysis does not generate quantitative output and is designed to identify and synthesize patterns within a dataset, rather than identifying the frequency of pre-determined characteristics present in a dataset (Pistrang & Baker, 2012; Vaismoradi, Turunen, & Bondas, 2013).

A major strength of thematic analysis is its flexibility (Braun & Clarke, 2006). As is the case with qualitative descriptive approaches (Sandelowski 2000, 2010), researchers are not bound to any epistemological, theoretical, or rigidly structured way of conducting their thematic analysis; instead, it can be adapted to match the needs of the research, and importantly, the actual content of the qualitative data (i.e., focus group interviews). In this way, a qualitative descriptive approach is particularly applicable for use with thematic analysis, such that themes are entirely

data-driven, minimizing undue bias inherent in a particular theoretical orientation or the researcher's personal biases.

Braun and Clarke (2006) define a theme as a label that, “captures something important about the data in relation to the research question and *represents* some level of patterned response or meaning within the data set” (p. 82). Themes are thus selected based on the investigator’s interpretation of the meaning they capture and their impact relative to the study aims (Braun & Clarke, 2006). Furthermore, the number of themes identified in a given dataset is driven by the analytic questions that the researcher aims to answer (Braun & Clarke, 2006). According to Creswell and Poth (2018), although the exact numbers vary depending on the research questions and study design, researchers are encouraged to aim for the following parameters: 25-30 final codes that are condensed into 5-6 themes for each research question. However, qualitative descriptive approaches allow for flexibility on this matter (Sandelowski 2000; 2010). Similarly, the prevalence of any particular theme is also subject to the investigator’s definition. For the current study, the themes considered to have the most impact were those that were present in every focus group; however, the investigator reported all themes present in at least half of the focus groups. This criterion serves the dual purpose of acknowledging variability in individuals’ experiences while also attempting to capture the extent to which certain phenomena are relevant across the sample.

Thematic analysis is a recursive process that requires repeatedly reviewing data, becoming immersed within the dataset, and moving fluidly through the different stages of analysis as necessitated by the research questions and data (Patton, 1990). Following the recommendations outlined by Braun and Clarke (2006), the current study cycled through the six stages of thematic analysis. First, the principal investigator became familiar with the dataset as a

means of developing a greater understanding of the depth and variability of experiences across individuals, focus groups, and the entire sample. This stage involved interview transcription in preparation for identifying and generating themes.

The next stage involves generating the initial codes by organizing the data in meaningful ways. Due to the method of recording group interviews (i.e., audio versus videotape), the research team coded for semantic content and excluded latent content (i.e., body language). The actual coding process involved assigning data to specific categories in preparation for grouping these codes into broader thematic categories. Codes were compiled into thematic maps that display the overall conceptualization of the data patterns and relations among them (Braun & Clarke, 2006).

The last three stages focus on transitioning from a specific, lengthy code list to a smaller, more fine-tuned list of broader thematic categories. Though Braun and Clarke's (2006) method does not specifically require multiple coders, in order to demonstrate the validity of findings, researchers conducting qualitative studies are encouraged to employ multiple validity checks, including some form of a peer review process in addition to comprehensive documentation (i.e., audit trail; Creswell & Miller, 2000; Rodgers & Cowles, 1993; Wolf, 2003). Thus, in the current study, the principal investigator enlisted a team of research assistants ( $n=3$ , excluding the principal investigator) trained in qualitative study designs.

The coding team met four times to: (1) train in qualitative methodologies and practices specific to the current investigation, (2) discuss preliminary codes and themes, and (3) refine the codebook and themes in preparation for the final report. The three graduate students and one undergraduate student research assistant independently coded each transcript and met twice to discuss their results; the faculty researcher oversaw the data collection and analysis process and

provided input to resolve any points of contention. The principal investigator created a preliminary draft of the codebook after the coding team coded the first three transcripts; this codebook was then used to code the final four transcripts. After meeting with the coding team for a second time, the principal investigator refined the codebook by incorporating the team's feedback and began to cluster codes into broader themes – only codes that appeared in at least four of the total transcripts were included. The next draft of the codebook was then shared with the coding team for additional feedback; all feedback was incorporated into the penultimate draft, which was then used to re-code the initial three transcripts to check for comprehensiveness and accuracy. Throughout this process, the principal investigator and research team reviewed the list of generated themes and refined it to meet Patton's (1990) criteria for thematic analysis - internal homogeneity (i.e., codes within each theme fall together in a meaningful way) and external homogeneity (i.e., there are clear distinctions between different thematic categories). All notes generated from the transcription and data analysis process were documented and included in the audit trail.

After the principal investigator and her coding team finished analyzing the data, all participants were invited to attend an optional, in-person debriefing meeting to discuss preliminary findings from the trial. This meeting was offered as an opportunity to allow participants to vet the researchers' identification and interpretations of the important themes and codes from the focus groups. Participants were not offered additional remuneration for attending this meeting. Although one participant completed the scheduling poll, no participants attended this meeting. This member-checking process is consistent with culturally-sensitive research practices and is a recommended strategy for establishing the validity of qualitative data (Creswell & Miller, 2000; Creswell & Poth, 2018). Lastly, the investigator produced the final list

of themes (along with de-identified quotations as examples) and reported on the “story” behind the data (Braun & Clarke, 2006).

## Results

### *Participant Characteristics*

All descriptive statistics were calculated using SPSS 26.0. Participants ( $N=54$ ) were, on average, 20.11 years ( $SD=2.52$ ; range 18-30). They were primarily undergraduates ( $n=39$ ; 90.7%); a small number were graduate students ( $n=5$ ; 9.3%). Participants were recruited using a variety of methods, including: 16.7% research website (SONA) ( $n=9$ ), 14.8% class/professor referral ( $n=8$ ), 22.2% email ( $n=12$ ), 14.8% student organization referral ( $n=8$ ), 14.8% peer referral ( $n=8$ ), 1.9% flyer ( $n=1$ ), 13.0% TelegRAM announcement ( $n=7$ ), and other 1.9% ( $n=1$ ). The distribution of participants’ mothers’ highest level of education was as follows: 18.5% high school ( $n=10$ ), 53.7% bachelors ( $n=29$ ), 20.4% masters ( $n=11$ ), 3.7% doctorate ( $n=2$ ), 1.9% medical degree (MD) ( $n=1$ ) and 1.9% other ( $n=1$ ). The distribution of participants’ fathers’ highest level of education was as follows: 1.9% elementary school ( $n=1$ ), 14.8% high school ( $n=8$ ), 25.9% bachelors ( $n=14$ ), 46.3% masters ( $n=25$ ), 5.6% doctorate ( $n=3$ ), 3.7% MD ( $n=2$ ), and 1.9% other ( $n=1$ ). Participants’ mothers primarily descended from India (59.3%;  $n=32$ ), Bangladesh (18.5%;  $n=10$ ), Pakistan (18.5%;  $n=10$ ), Nepal (1.9%;  $n=1$ ) and Sri Lanka (1.9%;  $n=1$ ). Participants’ fathers primarily descended from India (61.1%;  $n=33$ ), Bangladesh (18.5%;  $n=10$ ), Pakistan (16.7%;  $n=9$ ), Nepal (1.9%;  $n=1$ ), and Sri Lanka (1.9%;  $n=1$ ). Participants’ maternal grandparents descended from India (66.7%;  $n=36$ ), Bangladesh (14.8%;  $n=8$ ), Pakistan (14.8%;  $n=8$ ), Nepal (1.9%;  $n=1$ ), and Sri Lanka (1.9%;  $n=1$ ). Participants’ paternal grandparents descended from India (64.8%;  $n=35$ ), Bangladesh (16.7%;  $n=9$ ), Pakistan (14.8%;  $n=8$ ), Nepal (1.9%;  $n=1$ ), and Sri Lanka (1.9%;  $n=1$ ). Notably, no participants’ families descended from

Bhutan or the Maldives. Most participants were born in the United States (63.0%;  $n=34$ ). Those not born in the United States had lived in this country for an average of 14.05 years ( $SD=5.48$ ) prior to their enrollment in the current study. A majority of participants were born in the United States and had at least one parent born on the Indian subcontinent (61.1%;  $n=33$ ). Next, a proportion of participants described themselves as immigrants to the United States, such that they were born on the Indian subcontinent (25.9%;  $n=14$ ). One participant reported that at least one of her parents was born in the United States (1.9%). Last, a few participants were born in another country besides America or the Indian subcontinent, but lived in the United States for at least three years (11.1%;  $n=6$ ). In regard to religion, 48.1% of participants reported that Hinduism was predominantly practiced in their household growing up ( $n=26$ ), followed by 37.0% Islam ( $n=20$ ), 11.1% Sikhism ( $n=6$ ), 1.9% Christianity ( $n=1$ ), and 1.9% Buddhism ( $n=1$ ). However, there was greater variability in how participants currently identified in terms of their religious affiliation: 37.0% Hindu ( $n=20$ ), 27.8% Muslim ( $n=15$ ), 9.3% Sikh ( $n=5$ ), 1.9% Christian ( $n=1$ ), 1.9% Buddhist ( $n=1$ ), 14.8% none/not religious ( $n=8$ ), and 1.9% Atheist ( $n=1$ ). According to guidelines published by the Centers for Disease Control and Prevention, 7.4% of participants had a current body mass index (BMI) ( $\text{kg}/\text{m}^2$ ) classified as underweight ( $n=4$ ), 59.3% normal weight ( $n=32$ ), 14.8% overweight ( $n=8$ ), and 16.7% obese ( $n=9$ ); one participant did not report her weight. The average BMI for the sample was  $24.01 \text{ kg}/\text{m}^2$  ( $SD=5.20$ ).

*Research Question 1: How do South Asian women living in the United States understand and discuss body image and eating disorder concerns?*

Thematic maps for both body image and ED concerns are detailed in Figures 1 and 2, respectively. Five themes emerged regarding how South Asian American women conceptualized



body image: ideal South Asian woman (appearance), ill-defined middle, ideal South Asian woman (values/characteristics), gender disparities, and bicultural pressures.

**Body Image: Ideal South Asian woman (appearance).** Across the focus groups, participants had a clear idea of what the ideal South Asian woman looked like. They globally described her as someone who possessed the following physical characteristics: light, clear skin (e.g., no acne or eczema), a hairless body (e.g., body hair), about 5'7", and with long, thick, virgin (i.e., never dyed) black hair. When describing the emphasis placed on maintaining idealized South Asian hair, one participant said:

...the standard is to have long straight hair instead of curls and regardless of what your hair type is. Like if you don't have that then you're gonna be *groomed* to have it, you know what I mean? Like, if it's not something you have, then it's something you should *get*. (Transcript 3)

This hair ideal in particular serves as a cultural symbol for South Asian women. This hair ideal was described as one of the strongest beauty symbols for women and appears to be born out of South Asian men's preference for this type of hair. As such, women who choose to cut, dye, or alter their hair in any other manner are considered to be "crazy, awful, or acting out," (Transcript 3) by other family and community members. Because this type of hair is so widely prized, South Asian women have come to understand that this hair carries social capital. For instance, one participant described how her mother cut her hair in order to punish her father.

...My mom she had – when all of us were like little kids she had really *long* hair – it was like the ideal long straight hair like down to her back. It was beautiful, right? And when you have four toddlers, you have a lot to deal with. I think my mom – my dad pissed off my mom or something, like they had an argument – and she cut her hair off, 'cuz she

knew that my dad loved it. So, my dad comes home – and she had hair falling down her back and up to her shoulder – and he was like, ‘oh my god what did you do?’ So, it’s like she used hair to get back at him – she cut off her own hair. And she was like, ‘oh I know you like it and you’d be mad, so I cut off my own hair just to make [you] mad.’” It was just something as simple as hair, but it was a big deal for my dad. (Transcript 3)

Relatedly, many participants explained how they experienced constant scrutiny of their body hair. Specifically, they were made aware of their body hair at a very young age, and were taught to feel ashamed if they did not cover, shave, or wax certain body parts (e.g., eyebrows, leg and arm hair) by other peers, most especially South Asian boys. For instance:

I think body hair is like a big thing that *every* South Asian girl can relate to. Even if you have thin hair, you can still relate. I had hairy legs, I had hairy arms, I had a unibrow that was so thick, I had a moustache – I had all of that. And I had people who made it very apparent – to let me know that I had body hair, like I couldn’t see it myself. I’m like, ‘don’t you think I can see it?’ (Transcript 3)

Participants also described a ceaseless pressure to have light skin, by any means necessary. This was usually achieved through genetics, by avoiding the sun, and/or using skin bleach. The most common example of a beauty enhancement was use of *Fair & Lovely*, a popular skin bleaching cream. Many participants described experiencing both verbal pressure and encouragement to use home remedies or follow pseudo health tips with the aim of achieving this light-skin ideal. These tips usually recommended home-brewed concoctions that could achieve closer alignment with the South Asian appearance idea, such as applying turmeric, yogurt, or some other easily accessible food or herb to the face or body with the hopes of creating lighter and/or clearer skin.

...the pseudo health tips – yeah, it’s like ‘rub this on your face, drink this’...like they’re not even health benefits – it’s all to get lighter skin. It’s not about your health, it all goes back to standards of beauty. (Transcript 3)

Applying this notion more broadly, it appears that participants were repeatedly told by older women, including mothers, extended family members, and community members (e.g., *aunties*) that if they did not naturally resemble the South Asian ideal, there were methods they *should* use to obtain it.

**Body Image: Ill-defined middle.** Whereas participants were easily able to identify physical characteristics associated with the ideal South Asian woman, they had more difficulty pinpointing the weight/body shape that this woman was supposed to have. Generally speaking, South Asian women were expected to be thin. However, women deemed, “too skinny” by others were expected to adhere to a “healthy” ideal, which as one participant from the first focus group described, is “not fat, but heavy...healthy and round so that they [parents] know that you’re eating well.” As other participants noted, it appears that parents and older generations have co-opted the term “health” to imply larger-bodies, rather than actual “health” as Americans understand this term. In other words, it appears that “health” has become a coded term for “large” or “heavy,” rather than signifying someone’s actual physical health status.

On the other hand, women deemed, “too big, or too chubby,” are expected to lose weight. Thus, it appears that South Asian women are expected to fit somewhere between the thin and “healthy” ideal, yet this middle is not properly or clearly defined. Although family and community members tend to comment on women’s bodies and appearance, they never specify what the ideal body shape is. Furthermore, this “perfect” body appears to be a moving target, depending on various factors, including shifting beauty trends, and which ideal (i.e., thin or

“healthy”) women in a particular community imbue with more social value. In sum, it is currently unclear what body type and shape South Asian women should be striving for; however, others make it apparent when they have *not* met that ideal.

There is a happy medium that nobody actually knows and it’s funny because they tell you this, and nobody looks the way they want you to look...but yeah appearance-wise I just feel like there’s just a happy medium, and no one knows what it is. Everyone can pinpoint when you’re *not* that happy medium. (Transcript 6)

As a result of this confusion, many women expressed feeling that regardless of what they did, that they felt powerless. In other words, “...people will find faults regardless. Yeah, you can’t win” (Transcript 2).

**Body Image: Ideal South Asian woman (values/characteristics).** In addition to physical characteristics, South Asian women are expected to uphold particular cultural values and traditions. Specifically, they are expected to always dress and behave modestly, respect their elders and remain subservient to men, and obedient, especially to their parents. Women who do not adhere to these values are considered to be rebellious, immoral, or perhaps “too Americanized.” Modesty was a code that emerged quite often across focus groups, both in relation to a woman’s behavioral conduct as well as her values. Similar to the ill-defined middle for a woman’s body weight/shape, participants described an unclear middle ground that South Asian women were expected to adhere to in terms of how they presented and conducted themselves. This quote highlights the complex intersection between appearance and body ideals and the value of modesty for South Asian women:

But I think that in South Asian communities, compared to Western communities, it’s not like that [common] to have big boobs and a big butt because there’s usually a focus on

being modest, so being bigger - it's kind of hard to cover it up. So, I think there's just like a medium, like an in between of like not too small not too big, but yeah, just like not too big, that's what they tend to focus on. (Transcript 5)

Thus, regardless of the woman's genetic makeup or natural build (e.g., larger breasts and/or buttocks), she is expected to cover herself or downplay these features so as not to appear disrespectful, lascivious, or anything other than what is expected of her.

**Body Image: Gender disparities.** As is the case with other cultures, South Asian women appear to be subjected to harsher beauty and appearance standards relative to men. For example, women's eating habits are surveilled to ensure that they are not eating too much or too little; men are not subjected to this same scrutiny. Further, men may comment on women's appearances in order to keep them in line with the South Asian female ideal; women are not afforded this same opportunity. Two participants captured these disparities clearly with the following statements:

And you can kind of see that throughout the generations. Like these *uncles* will be fat – and look not appealing, and their wives are beautiful and skinny – and it's kind of like an expectation. Like guys can let themselves go and it's like 'okay, whatever,' like that's not the most important thing. But women just have, I don't even know, like if they're just more – like [if] they have more meat on them, it's like 'oh, you should kind of tone that down, you know, to look good for your husband,' and this and that. So, it's like expectations on gender, like this topic [body image], it's more so geared towards women in the South Asian community, and not men at all. (Transcript 3)

And something that was really irritating growing up was like all my male cousins – nobody ever said anything about them. They would just sit there and have competitions about eating food and nobody said a word. And as soon as we said – like any of the girls

picked up any food or anything – it was, ‘okay, maybe you shouldn’t eat that.’ So that was also a very frustrating aspect of growing up. (Transcript 3)

At the heart of these gender disparities is the pressure for South Asian women to attract and marry South Asian men within an acceptable time frame. Typically this means finding a partner during their undergraduate years and marrying soon after graduation. Many participants expressed that older women, including extended family members, community members, and mothers, would pressure younger women to fit a particular physical ideal in order to make themselves more desirable for marriage (e.g., maintaining the South Asian hair ideal). To prepare for marriage, many women received comments from other women about the need to modify their appearance specifically for the purpose of attracting a male, *Desi* suitor (colloquial term that South Asians use to self-identify as descendants of the Indian subcontinent).

...I feel like it all does go back to gender roles that are so ingrained in society and culture. But it’s almost like you have to look a certain way because you’re being groomed to be somebody else’s property, essentially, right? Like you need to have market value, so you can partake in ‘the business that is marriage.’ (Transcript 3)

Thus, it appears that securing suitable marriage prospects is one of the strongest forces driving appearance pressures for South Asian women.

Lastly, South Asian women, unlike their male peers, are typically expected to explain their whereabouts to their elders and come home before dark as a means of protecting their physical safety and sexual purity. This latter expectation may be a function of cultural norms surrounding filial piety, which include obedience and showing respect to elders, as well as an expectation to protect one’s sexual purity for marriage. These sentiments are captured in the following conversation:

P1: Because there are terrible people in the world – and especially in India with the rape statistic – it’s so dangerous to go out at night. It’s just about safety I think...your family literally just wants you to be safe and sound.

P2: That’s the difference between guys and girls.

P1: Yes, guys can stay out however, as long as they want, and that’s what just creates that huge disparity between men and women. (Transcript 1)

**Body Image: Bicultural pressures.** Last, participants expressed numerous appearance-related pressures associated with adhering to multiple cultures’ value systems and appearance standards as a result of being South Asian while growing up in America. They identified three prominent pressures: differences between South Asians living on the Indian subcontinent versus expectations for South Asian women living in the United States; differences between South Asian beauty ideals, which tend to align more with a Eurocentric ideal of beauty, compared with relatively more diverse appearance ideals in America; and a dual appearance pressure from identifying as a Brown, South Asian woman while living in a predominantly White, America.

Participants described how more conservative values are enforced in South Asia, whereas South Asian values are enforced to a relatively lesser degree and are intermingled with American values for South Asians living in the United States. As such, South Asian American women are afforded more freedom relative to their South Asian peers and relatives living on the Indian subcontinent. For example:

I was in India this past summer...before I left [my grandmother] was like, ‘you know, I know that you’re smart and I know [what] you’re like in school, but next time I see you, your skin should be a little lighter, and your hair should be longer and darker, and you

need to drink beet juice every day because your aunt on this side did it a month leading up to her wedding and she was glowing.’ (Transcript 3)

Next, participants described how American (synonymous with White) culture tends to idolize relatively curvier women, such as the Kardashians, whereas South Asian appearance ideals tend to align more strongly with a Eurocentric ideal of beauty (e.g., thin ideal, white, lighter skin). Participants describe how they believe that South Asian beauty standards have mapped onto Eurocentric ideals as a result of colonization and an internalized desire to be White. In addition to the fact that American beauty trends seem to be constantly shifting, participants also acknowledged that American culture tends to appropriate these trends from other cultural groups, including South Asians. As two participants explained:

...we’ve Westernized ourselves. I can talk about this with specificity for how the British took over both Indo-Pak and stuff like that – that’s up to my knowledge. I don’t know about any other country – but, like ever since then, I feel like we’ve had this whole idealized beauty of White, Western beauty. And that’s what we’ve been trying to get at. I mean I don’t really know what times were like before then – maybe they still wanted to be White – but since then, we’re just constantly in this effort to have Whiter skin, be skinnier, be taller, like even – I mean, we even dye our hair lighter colors now too. We’re trying almost everything... (Transcript 2)

I think of it as more Eurocentric beauty standard, rather than South Asian versus American, because American beauty standards – they change. It used to be thin eyebrows, but now it’s like, ‘oh the thick eyebrows are in,’ and it used to be thick-skinny and now it’s like, ‘oh now curves are in,’ this and that. So, it like changes *a lot*, so I think it’s *not one thing*. I think it’s like whatever they like from whatever culture – let’s just



make that the newest thing American beauty standard. But in terms of like South Asian beauty standards – that’s like completely Eurocentric. Fair, long hair, skinny – all that kind of thing. So, I think Eurocentric beauty features are probably all over the world. Like fair skin is what people, who – like it’s ingrained in people to strive for fair skin, to strive to be skinny, that kind of thing, that White people wherever they travel, they kind of – like in that culture – they ingrained their Whiteness in that culture and that’s where everybody looks for beauty in Eurocentric features. I think America was like that for a long time, but Americans like whatever they like from whatever cultures they take and adopting it and that’s why it always changes. So, I don’t think America has a certain beauty standard ‘cuz I know in a few years it’s going to change. Being curvy is not going to be “in” anymore – it’s going to be something else. So, I think it’s very hard as a South Asian woman to try to defy South Asian beauty standards, but also not fall in the track of American beauty standards, but also like accepting yourself – it’s a constant battle. All the time. (Transcript 3)

In general, South Asian women felt that they had less flexibility in terms of body positivity relative to White women, and also had trouble reconciling American beauty trends (e.g., tan skin, dyed hair, blue eyes) with South Asian ideals (e.g., light skin, virgin black hair). Furthermore, participants described how relative to White, American culture, which generally accepted a larger range of body shapes and sizes, South Asian women were expected to always be dissatisfied with some feature of their appearance, whether this be their body shape, their skin tone, or some other prominent feature. This body dissatisfaction tended to be internalized after someone in the broader South Asian community (e.g., *aunties*) or family members would persistently provide negative comments about the said feature. In fact, one participant reported

that “...if you’re happy with your weight – especially if you’re overweight and you’re happy with your weight – it’s such a problem...they get so mad” (Transcript 3).

Women also described a range of experiences when attempting to reconcile the dual appearance pressures of upholding both White, American and South Asian beauty ideals while living in America. Whereas some women expressed a desire to downplay their South Asian features as a means of fitting in with their White peers, others found solace in their ethnic identity. One participant poignantly captured these pressures:

Like, here [United States] you have – like I guess on some parts are similar – but like if one side of like – we kind of live in a dual culture thing and we try to find our balance. And I grew up in [redacted] but surprisingly, I didn’t grow up around many Indians ‘cuz I went to I think the one school in [redacted] that had *no* Indians and so it was me dealing with a bunch of American culture here, and then going home to my super traditional family. And so, I think it was hard for me to find the balance because it’s like, on one side – it’s like being skinny is like the *American thing* and then going home and your parents being like, ‘why aren’t you eating enough?’ I think it was just a hard thing to deal with. (Transcript 3)

Despite this dilemma, it appeared that there was a global movement towards rejecting *all* beauty ideals – whether they be the White, American ideal or the rigid South Asian ideal – usually by taking pride in the unique beauty offered by South Asia. For instance:

Women are very much *into* Western beauty. But if I talk about us – like, from India – if you talk about Aishwarya Rai and many other celebrities from all over the world – I mean, we are beautiful. Right? We don’t have to be beautiful as Western people are... (Transcript 2)

Furthermore, participants repeatedly stated that the South Asian ideal in particular, because of its alignment with the Eurocentric ideal (e.g., thin ideal, white skin), was unattainable and unrealistic and acknowledged the potential physical and psychological harms in pursuing this ideal.

...and there's just no way you can win, 'cuz like how can you have the perfect body shape according to them? (Transcript 4)

[*Fair & Lovely*] is constantly advertised – it's so annoying. You know, we aren't White, that's not us – we have melanin. If you're putting something on your skin and it's changing the color of your skin – that's called skin bleach. (Transcript 3)

Finally, participants identified both American and South Asian media (i.e., Bollywood) as prominent transmitters of appearance ideals for South Asian American women. Bollywood icons influence the way that South Asian women view themselves and are supposed to represent the current South Asian ideals. Bollywood tends to reflect the thin, Eurocentric ideal that used to be more pervasive in Hollywood. However, some trends associated with Western culture, such as social acceptability of women wearing little clothing, conflict with traditional South Asian cultural values. Therefore, in South Asia, appreciation for Westernized beauty has to adapt to fit within a South Asian cultural framework. Thus, it appears that South Asian women receive the same message (e.g., conform to the Eurocentric ideal), from two very different outlets.

“...I think that media has been...if you're *not* from like a *Western* country, media is really like universal so like, I feel like it's really heavily based on Western influences and styles and fashion and body images, beauty standards, etc. So, I have a cousin and she's lived in India all her life or whatever. And so I know she tells us to send [her] things that are really like fashion or clothes or whatever from America or whatever that she wants, so I

think they really pick up on that and try to like – and I think that's where kind of like sometimes, like, *conflicting* ideas kind of come in. 'Cuz her parents are still very traditional, but she's being more exposed to the media so she realizes like, 'oh this is what's more "in" or whatever,' so I feel like that's kind of contradictory. (Transcript 5)

Five themes were identified for the ED domain: food culture, centrality of weight, Superwoman complex, interpersonal pressures, and cultural stressors. Each theme is discussed in detail below.

**Eating Disorders: Food culture.** Although the primary research question did not pertain specifically to food, while coding the data, the research team found that it was impossible to discuss body image and EDs without first understanding how South Asian communities view food. Food is a central feature of South Asian culture. Specifically, food connects different immigrant communities in the United States and reminds participants of their childhood, their cultural roots, and provides comfort. As is the case with other cultures, food appears to be a central time- and labor-intensive practice within the South Asian community. Specifically, the practice of making and eating food facilitates important social interactions between family members, community members, and other important figures.

I think it [food] touches almost every part of our lives. Like if you're religious, if you're not religious. Like you grow up with it and having certain types of food at certain times. It really connects you to what you would do there. Like if you go back to Pakistan or India, you'll always find the same food that your mom would make on the street so that's pretty cool. It's something you can share really easily. You can't really share many things really easily, but food is easily translated. And I think especially when you're not living in your home country, that's one thing you can relate to people with very easily and

people are connected – like you said – by food especially when you live in America or somewhere [else]... (Transcript 3)

Indeed, food is revered to the point where refusing it is considered a sign of disrespect, regardless of an individual's satiety level. Although this appears to be a practice held by both South Asians living on the Indian subcontinent as well as those living in the diaspora, it seems that this principle is also tied to food insecurity for South Asian immigrants. For instance, one participant reported that she felt that her mother repeatedly gave her more food throughout childhood as a way of “showing her love.”

Yeah about the thing about piling on food. So, my mom – my parents had me a year after they came to America so like, my mom grew up really poor, and she was, she didn't have food available to her, and so I – like me making my own connections – I feel like she would pile on food for me to make up for – like ‘oh I didn't have that food available, therefore I want my daughter to eat as much as she could.’ And I understand that, but at the same time, it wasn't a healthy living style, you know, like, I shouldn't have been fed that kind of food or so much...And so, that's how I feel like my parents would, I guess, show their love... (Transcript 6)

Last, many participants made remarks about how “oily, fatty, and carb-heavy” South Asian food is, implying that although South Asian cuisine provided a form of comfort and connection to their cultural roots, these feelings were tempered by possible guilt associated with eating large quantities of these types of cuisine. For instance, one participant remarked that, although she was a fan of a classic Indian rice dish, *biryani*, she felt it was just “rice [and] carbs...it could be healthier” (Transcript 4).

**Eating Disorders: Centrality of weight.** Participants repeatedly described ways in which older generations, especially women, emphasized younger women's weight, particularly how their weight *appears* to others. Weight reduction appears to be more important than any other index of health and is sometimes even encouraged at the expense of physical or mental health. Thus, weight stigma, regardless of the woman's actual weight status, appears to be a particular stressor for South Asian American women. Specifically, younger women reported experiencing fat- and skinny-shaming as a means of keeping them in line to meet the "ill-defined middle" body shape ideal. Comments usually come from people to whom the woman is not as close, such as extended family members, family in South Asia, and/or family friends (e.g., *aunties* and *uncles*). Women are also praised when they diet, starve themselves or restrict foods; conversely, women who are perceived as overeating or "too fat" are shamed.

I think the one thing that I hate when I visit India is that my relatives always comment on how skinny I am. And they're like, 'you need to put on more weight,' and, even if you gain weight, and you look a little bit fat, then they comment on that too. So, it's like, 'I can never please you.' And you can never say no to food because they think it's insulting to them. So, you can't – like no one is winning. (Transcript 1)

Mothers and older women appear to be highly attuned to weight and make direct comments to younger South Asian women as a means of providing some gauge of how the woman is measuring up to the South Asian "ill-defined middle" ideal:

But even with my roommates, my mom was like, 'she gained 14 pounds'...My mom could pinpoint it and I was like, that's crazy, the way she just – she knows and I don't pick up on that. (Transcript 4)

However, younger women remarked that they believe that weight is not a good indicator of health and that others in the community were not acknowledging that certain medical illnesses, such as thyroid issues or diabetes, could also affect a woman's weight status beyond their control.

You cannot look at someone and be like 'you're healthy, you're not healthy' based on their weight. It's impossible. Except some people have fast metabolisms, like it's just not something that you can do. (Transcript 3)

Well my mom also has a thyroid [condition], so that puts her on the other end of the weight scale so she's chubby. But the thing is that's why we all started eating healthier, because she has thyroid issues – and she needs to maintain it, like she can't lose weight. The second I was born, she got thyroid, and after that she never changed her weight. It's always been high, but people are always thinking that she makes all these fatty foods, always deep frying stuff and whenever we have people over they're giving advice to her and she's like, 'you don't know me.' Like *they don't know her* because she has a health issue and all – I feel like a lot of Brown people have health issues that they don't talk about... (Transcript 3)

**Eating Disorders: Superwoman complex.** In addition to maintaining a perfect weight, women repeatedly described how their family and community constantly expected them to maintain a general air of perfection. Specifically, South Asian women are expected to juggle multiple roles, such as being a housewife, mother, wife, student, as well as obtain and maintain a lucrative, prestigious job. Simultaneously, they are expected to appear presentable and achieve the highest possible standards (e.g., highest grades on assignments). In other words, South Asian

American women have to “...deal with everything at home and everything at school. [They] have to do it all now...and [they] need to look good while doing it” (Transcript 7).

Participants described that these pressures were much greater for women relative to men, and related to the South Asian female ideals of modesty, respect, and obedience – all qualities considered essential to marry well. In sum, as a South Asian American woman, you are expected to be a “Brown Wonder Woman” (Transcript 6) – to do it all, perfectly and without complaint:

I think there’s that assumption that you’re supposed to have time for everything. To be able to take care of yourself and your body and everything, but also take care of your family, and your elders, everybody in the house, because it’s always multi-generational. You need to cook, and now more and more women are going to work, but that’s not reducing any of the work they do at home...And while doing all that, you have to – as a student – you have to keep the best grades. And so, you have that weight on you also.  
(Transcript 1)

**Eating Disorders: (Inter)personal pressures.** Thinking more about the cultural context for these appearance-pressures, participants described how South Asian American women experience body and appearance pressures from multiple domains, including other similarly-aged peers, extended family and community members, parents, and themselves. Across a majority of focus groups, participants reported that they felt pressured from the greater South Asian community to uphold traditional ideals and values. Specifically, participants described how all news is community news. Nothing is secret and it is socially acceptable for people to bluntly comment on women’s appearances and weight. By extension of this, community members and distant relatives have free license to comment on other children’s lack of progress, in terms of appearance, grades, roles, and more. Usually these comments are immediate, such



that when women first encounter a relative or community member after a long period of time, they usually receive a negative comment about their physical appearance (e.g., skin tone, weight status).

...the sense of community there is with *Desis* – it's not just your business. It's not just you and your family. It's you and your family, and your mom's friends, and their extended family and – like, everyone has a right to say on every – because parents are ultimately giving other people the right to say stuff about their kids and that's one thing that I've never been able to comprehend to this point. Like, why does the next door *aunty* think she has a right to tell me I'm fat or something? (Transcript 2)

Furthermore, it appears that appearance pressures and encouragements to engage in behaviors to uphold such ideals are maintained by a social stigma and fear of others speaking ill of you and your family:

...But it's always like, 'what are other people going to say?' kinda thing and that's a huge problem especially in the [South] Asian community because we're always thinking like, 'what are people going to say about it?' It's like, why does that matter? 'Cuz like at the end of the day, you're the one living with that career, living with that body type. Why does it matter what other people have to say about you and stuff? So, I think that's kind of a battle a lot of people have in the community. (Transcript 4)

In addition to community pressure, women repeatedly cited parental influences, such as perceptions of high control, pressure, and expectations, as important factors to consider in regard to appearance and ED concerns. Specifically, women are expected to follow their parents' rules without question and are expected to look and act a certain way in order to represent their family well to others in the South Asian community. These pressures are usually maintained through

social comparison (especially between siblings/peers). In fact, participants reported feeling both explicitly and implicitly guilty into doing well for their families. For instance:

But then also like, ‘oh, we came from India for you. For our children. So, you should be thankful, and you know, studying your butt off and doing all these things that we tell you to as well because we want us to look like – us as a family – to look good.’ And there’s that whole thing of, ‘we want to be proud of you, we want you to be successful and be able to build a stable life for yourself.’ But it’s also very selfish sometimes. (Transcript 1)

... you’re just expected to just be okay, like, it’s not okay to *not* be okay and – growing up here as like a first-generation – I don’t know, like I’m the first to be born here, to go to school here, to go to college here in my *entire* family, so it just feels like there’s a lot of pressure because I know my parents moved here so that, you know, me and my brother could have like a better life and stuff like that so it’s more added pressure to satisfy not only what *they* had expected of us, but like I want to make them happy. Stuff like that – so it’s just hard to balance all of that with *the times*, and you know, school’s hard.

(Transcript 7)

Lastly, participants described how that, partly as a result of the messages that they received from their parents growing up, that they had internalized a set of self-imposed perfectionist standards. Some participants acknowledged that they have high expectations for themselves when it comes to both their appearance and academics. For some, they expressed internalizing pressure to do well as a means of protecting, honoring, and respecting their parents’ struggle, which is usually tied to their immigration experiences.

I think it’s like that in a lot of, like if you’re - OK, you being a model minority has a lot to do with a lot of us, like our parents are immigrants – and so you kind of want to reflect

and respect their struggles, and you don't want be a disappointment to them because they did *so* much to get you to where you are. So just having respect *to them*, and appreciation *to them* - because I don't know about you all – but for me I could never (inaudible) my parents for getting up, living their dream – with kids – coming here, struggling, and giving me everything I could have asked *and more*. So, for me, I'm like, 'I'm gonna do my best just to like give – because they did so much. The least I could do is get good grades, and not party and not get drunk...' (Transcript 3)

**Eating Disorders: Cultural stressors.** In addition to the pressures enforced by various South Asian individuals, participants described a series of culture-specific factors that affected their self-esteem and appearance, such as racial discrimination, marginalization, and experiencing difficulties trying to navigate two distinct cultures (i.e., America and South Asia). Participants described multiple instances in which they experienced explicit racial discrimination and teasing by White peers. As mentioned earlier, the nature and occurrence of these discriminatory experiences usually influenced whether a South Asian American woman felt that she wanted to align closer with her South Asian heritage or attempt to downplay South Asian features as a means of assimilating into White, American culture. One participant described the struggles that she faced in terms of how assumptions associated with the model minority stereotype influenced others' perceptions of her:

We're more known for our brains than our looks, so it's just like when you hear things like, 'oh you're really pretty *for an Indian*'...it kind of exemplifies like that, 'oh wow you're smart *and* you can be pretty.' It comes as a shock. I think that growing up, we were raised to be obedient and smart and stuff like that, but people think that those are the

dominating characteristics of us, and we can't look good and stuff like that. So, when they come across a "pretty Indian," they're shocked. (Transcript 4)

Furthermore, one participant reported that she distanced herself from being Indian in certain ways to avoid confirming racial stereotypes about South Asians. This phenomenon is also known as stereotype threat (Steele, Spencer, & Aronson, 2002).

I've been put in a little *box* by a bunch of other people where it's like, 'oh my god did your parents force you to do this?' and 'are you doing this cause your parents want you to?' And it's like, no. But they think of me as every other Brown chick whose parents all forced us to become doctors and dance with jingles on our feet. I don't know. I think that's, for me I tried to *not* act – I feel like I act a little bit less Indian, I would say, just because I am doing a thing where I feel like I need to act a little less Indian with all my other [hobbies]... (Transcript 6)

Additionally, some participants reported that at times throughout their childhood, especially within the educational system, it was evident that they were "the *only* Brown person in the room" (Transcript 5) and were treated differently as a result of their racial status. However, some found solace outside of school by associating more with their respective South Asian community.

Yeah I feel like I also grew up in [redacted] and the school that I went to was predominantly White and just upper-class White people, so, I did always feel a little bit different at school. So, my parents also have – we don't have a lot of family here, but my parents are still very social, and they have a huge group of family friends I guess, and they're all Bengali as well so, at school, it was like I felt a little different, like I stood out a little bit. But my family friends, 'cuz they were all Bengali and, I could relate to them

on certain things, like food and clothes, and Bollywood movies and stuff like that...

(Transcript 5)

Finally, participants described experiencing a unique tension as a result of clashes between different cultural values upheld by their parents (i.e., traditional, conservative, collectivistic South Asian values) and their current generation in the United States (i.e., liberal, individualistic American values). Many participants described feeling pressured by their parents not to betray their heritage or cultural roots, and experienced criticism if they acted or appeared “too Americanized.” As a result, many participants described how they try to find a balance between both cultures by “...not being *too* Indian to the American side, and not being *too* American to the Indian side” (Transcript 7).

I feel like our parents – they grew up in a very different society, very conservative, very obedient – and growing up here they don’t understand the culture change and societal change. And then for them, they’re like, ‘oh we listened to our parents and look we’re happy, we’re successful.’ But I feel like also they don’t realize “happy” is a very subjective term, like their definition – like my parents’ definition of being happy or my dad specifically is like ‘oh you have a good career, a good family, blah, blah, blah,’ and to me happiness is, ‘am I comfortable in my own skin, am I satisfied at the end of the day? Like do I need - if I feel like I’m lacking something, then I’m not happy.’ Being a doctor isn’t necessarily going to make me the best person. It’s being comfortable in my own skin and being able to do what I want to do is more important than, you know, your [parents’] definition of happy. And I think that growing up in the household it’s very easy to forget that, but as you come here [VCU] and start talking to different people on your own – not under them 24/7 – you start to realize it a little bit more. So, I agree that our

parents have done a lot – like the journeys are definitely difficult, and at the end of the day they'll like – when they're gone, then what are we fulfilling at the end of the day? Like the hopes and dreams of people who aren't even here anymore. At the end of the day... (Transcript 4)

*Research Question 2: What are barriers and facilitators to ED treatment for this population?*

The thematic maps for barriers and facilitators of ED treatment are detailed in Figures 3 and 4, respectively. Participants identified six major barriers to ED treatment, including: Eastern versus Western medical views, stigma – social and general, parents' mental health, lack of knowledge about mental health and EDs, lack of South Asian representation, and healthcare provider bias.

**Barriers to EDs Treatment: Eastern versus Western medical views.** In general, participants described how older South Asian generations tend to prefer Eastern medicinal traditions that have been passed down over the centuries over newer, Western medicinal philosophies (i.e., medication). Participants also noted that their South Asian parents and older generations distrust Western medications for a variety of reasons, including fears of addiction, as well as concerns about side-effects and long-term effects.

I could see it for the side-effects maybe, and I know my parents they don't want – they think, when you start taking medicine, you become not addicted, but they don't think that taking medicine is the best way to fix your problems. And my mom, she's really into herbal things... But a lot of times, that's not the only way to cure certain things, so I think they're just scared of – like my mom says, 'I don't want you to be on certain things at such a young age. You're so young right now, you have so much to live for. So, if you start taking medications right now, then when you're old, what's going to happen to your

body?’ sort of thing. So, I think – in their minds – they think of the side-effects right now and then the future effects of the medications. (Transcript 4)

As alternatives, many parents prescribe more natural, homemade *ayurvedic* forms of medicine or suggest pseudoscience tips as cures for their children’s mental health symptoms. These tips usually lack any sound scientific basis and are often transmitted through social media tools, such as chain messages on WhatsApp or posts on Facebook. Although participants were wary of following their parents’ misguided health tips, they were more accepting of their parents’ use of homeopathic remedies.

And it’s also the fact that, especially on the Eastern side, that more natural medicine is used. It’s more *ayurvedic*, like that we made our own concoctions, and that’s what we know – or we think we know what’s good for our body – and then we come here and it’s all pills and over-the-counter medicine. Yeah, we’re skeptical of that. (Transcript 1)

Thus, it appears that herbal remedies are deemed more acceptable and widely available as forms of medication for South Asian American women, compared with Western prescription medications. In addition to this distinction, participants described how many of their parents and older relatives relied on religion as both an explanation and intervention for generalized mental health concerns and EDs. Many participants remarked how when they attempted to discuss their mental health concerns with their parents, they were told that their problems betray a mistrust in God, or that they might be possessed. To cure these misgivings, participants were often told to “pray away” their depression, anxiety, and/or EDs:

And I think the way South Asians view mental health is broken up into social stigma and then cultural, religious, like impatience. I’m Muslim – and no one said this to me – but it’s like, ‘oh, you’re depressed? Just pray it away.’ It doesn’t do anything; there’s doctors,

professionals, there to help you, but if you go there, you are crazy. ‘Oh, you’re saying you have a mental illness, are you not content with God or something like that?’ So they use religion. (Transcript 3)

On the whole, it appears that South Asians have created alternative explanations for the presence of mental health concerns and believe that these concerns can be cured through Eastern-based, homeopathic or religious means rather than Westernized medicine.

**Barriers to EDs Treatment: Stigma - social and general.** Many participants described how older generations of South Asians, including their parents, expressed both a social and general stigma about mental health. In the infrequent cases when mental health concerns *are* acknowledged, they are viewed as temporary phases and states of being rather than potentially chronic health conditions. In contrast to the bluntness associated with appearance-related comments, mental health conversations are silenced and shunned. Specifically, older generations are fearful that if community members discovered that they were experiencing any mental health issue, they would be shamed, judged, and socially ostracized. It appears that this particular fear of *social* stigma maintains a culture of silence surrounding mental health, and thus, poses a strong barrier to treatment-seeking for South Asians.

And then socially like, ‘oh like what are people going to say? *Log kya kahenge?* [What will people say?]' And I’m like, ‘who cares what people are going to say about me?’ So, I feel like it’s split into, one it’s not taken seriously, and then it’s the social consequences of you saying that you have a mental illness... (Transcript 3)

Because of this culture of silence surrounding mental health, many South Asian American women reported rarely feeling comfortable confiding in their parents about their struggles, and thus, felt generally under-supported and alone. Furthermore, to discourage



members of the community from seeking care, those with possible mental health conditions are labeled as “crazy” or “contagious.” Thus, participants noted that the existence of mental health concerns and EDs is generally denied and thus, these issues are not taken seriously until they become physical and visible. As a result, there is no prevention, only intervention. Parents will usually only acknowledge the existence of mental health issues when symptoms became severe enough to be physically obvious and/or warrant medical attention.

**Barriers to EDs Treatment: Parents’ mental health.** Although focus group questions were directed towards the participants’ experiences with body image and ED concerns, many women also expressed that they suspected their parents silently suffered from mental health issues, such as anxiety and depression; but, according to participants, their parents perceived these conditions as part of life, rather than treatable illnesses. Specifically, participants commented that many parents viewed these concerns as natural outcomes of the immigration process. Parents experienced unique hardships and struggles when they immigrated to America. However, this process was considered necessary, and participants implied that parents and older generations did not allow themselves to view this experience as potentially traumatic. As a result of these unacknowledged “traumas,” participants described often bearing witness to parental suffering and sometimes experiencing secondary distress related to their parents’ potential “trauma”, feeling parentified, and trying to help their parents.

But I think that my parents don’t have the language to talk about mental health in the same way, in the same language that I do. So, my dad doesn’t really talk about it, but my mom has been opening up more and more, about just the *trauma* of immigrating. And not having anybody here and just rebuilding a whole life. Just complete loneliness basically until I was born. And she’s been opening up more about that. And, in my mind, I’m like,

‘no duh, you’re [depressed].’ But like, just thinking of patterns, and I think that’s one of the reasons that I’ve had like a different context, that I talk about with my therapist. But she’s not labeling it as like “different,” or PTSD or anything. But she’s talking about it more with me as in a[n] unloading way. Which I like, but I’m also, like, part of my own base of mental health issues come out of things that she’s done emotionally to me and a lot of that is because of things that were done emotionally *to her* from her in-laws, and stuff like that. So, I’m just like, ‘I can’t talk about this with you, but a lot of this is making sense now in my own head,’ but yeah. In my family, at least, there’s more openness about talking about *those* kinds of feelings but without making it into like a “mental health” kind of way. ‘Cuz I think that scares them, that thought system. ‘Cuz I think they think of it as like “American.” But they’re – at least my mom is – more open to talking about just feelings. (Transcript 1)

Furthermore, because South Asian parents immigrated to the United States with the intention of providing a better life for their children and future generations, many participants described how any struggles or concerns that they experienced were viewed as “less than,” unjustified, and/or problematic.

...I remember one time in high school I was so stressed because I was doing the IB [International Baccalaureate] program and was trying to get the diploma, and I was like, ‘I’m stressed’ – and rightfully so it’s a stressful program – and my dad overheard me saying that and he got so mad he said, ‘you have no right to say that you’re stressed, you don’t know what stress *is* and you don’t know what *anxiety* is. You don’t know what this or that is like – you don’t have a *right* to *feel* that,’ and he was like, ‘that shouldn’t even be in your vocabulary.’ So, you know it’s a thing when even the *symptoms* are looked

down upon and they're like, 'no you're supposed to be happy because you have everything you could possibly ever want.' (Transcript 3)

In other words, the struggles of the children, including mental health concerns and EDs, are viewed as incomparable to the struggles of the parents and generations that came before them. These discrepancies in defining life stressors and difficulties might pose additional barriers that make it challenging for South Asian women to discuss their ED and body image concerns with their parents, and by extension, seek treatment. Perhaps parents' own potential mental health concerns (including those possibly related to immigration) could influence their capacity to help their children address mental illnesses.

Last, participants discussed the fact that South Asian women in particular are not allowed to express any negative emotions, as this is considered a sign of weakness. Women are discouraged from discussing their concerns with anyone and are expected to maintain perfectionism, tranquility, and a calm demeanor at all times. Women are taught from an early age that emotions are not only useless, but they can be harmful. Participants described difficulties associated with this expectation, as they often witnessed how their mothers would not only try to hide their own suffering but would also inadvertently transfer this emotional pain onto their daughters. For instance:

I remember there was this one time where, I think my father said something insulting about my weight and, I started crying and my mom was like, 'you shouldn't cry, stop it, don't cry.' Because that's what she's been growing up with. I know typically in all families, you never see the dad cry, like the stereotype. I rarely see *my mom* cry, and because it's been taught to her that it's not worth crying over – it's still mental...because she doesn't think it's that important. She even told me that when she came to India –

when she got married, maybe a month after – she didn't cry when she came here and said goodbye to her parents because she was just taught not to. She should be strong. She needs to take care of all these things like cooking [and] cleaning. She also goes to work, so there's just no time for emotions in all that. (Transcript 1)

**Barriers to EDs Treatment: Lack of knowledge about mental health and EDs.** Older generations of South Asians do not fully understand, acknowledge, or accept the existence of mental health and EDs. This lack of understanding usually manifests in the form of jokes and humor to dispel any discomfort surrounding the topic of EDs. For instance, one participant described how, after being away from home for some time, her parents asked her, “Oh how did you lose so much weight, did you starve yourself?” (Transcript 1) implying that she was intentionally restricting her food intake.

Furthermore, parents avoid seeking mental health care for their child because they are fearful that they will be blamed or labeled as a “bad parent,” or that they were somehow culpable for their child's mental health condition. It appears that this tendency to self-blame arises from the fear of social judgement they anticipate would occur if word spread that their child was seeking treatment for a mental illness. Thus, participants discussed how they believed that this concept of parental self-blame was one of the main factors that prevented them from seeking ED treatment, relative to White women.

...I feel like if a White woman – like if people find out that she has an eating disorder – then she goes to the hospital or something, they do what they should do, they extend their care and they help that person. And I feel like it's kind of just – a lot of South Asians may think about their reputation more than they do about caring about that person. Like, ‘oh, she's in the hospital because she has an eating disorder. Now I'm seen as a bad mom

because I should have, you know, told her to eat more or something.’ So, it’s like, they care, but it’s also that aspect of their reputation that they care about too, which I feel like with White people, that’s not really how it is. (Transcript 2)

Furthermore, participants described how their parents experience difficulty broaching the subject of mental health concerns, including EDs, with their children because they do not possess the knowledge or language to understand these phenomena. For instance, they might utilize coded, generalized language such as “stress” to refer to any form of mental health:

Back to talking about mental health, I feel like my parents will talk to me about stress, but that’s the furthest they go. So yeah it’s just about stress. They know that I’m stressed about doing well in school and things like that. So, my dad, he calls me [and] he tells me ‘here’s some study tips. You should go do something fun and to relieve yourself a little bit,’ but like that’s as far. But I feel like they only do that though because they have an understanding of what stress is – at least part of it – but they don’t understand other factors of mental health so that’s why they just stop at stress and make a big deal out of that. (Transcript 7)

With respect to EDs in particular, many participants noted that their parents do not consider EDs to be true disorders or problems. Parents and older generations do not conceptualize *food* as disordered; thus, if a woman is viewed as “too skinny or too fat,” the solution is to “just eat more, or just eat less.” As a few participants describe below, symptoms and behaviors typically associated with EDs are viewed as functional, typical, or possibly acceptable:

But I think *eating disorders* – I don’t think I’ve ever heard a Brown household talk about eating disorders...I think with eating – like in general, in Brown households – I’ve seen,

“oh too thin or too fat” like that and *eating* – and like, *weight* is talked about. But eating *disorders*? They brush it off. It’s not even – like there might be a reason behind how you’re eating, like it’s just like, ‘oh, it’s not enough or it’s too much.’ (Transcript 3)

... I also don’t think parents see bulimia as an eating disorder ‘cuz they’re like, ‘oh you just ate too much, and then you threw up.’ I don’t know, they just don’t see it. (Transcript 5)

Although the current generation understands the high prevalence and seriousness of more publicized mental health conditions, such as suicide, depression, and anxiety, they admitted that they could benefit from more psychoeducation about EDs specifically. They acknowledged the existence of EDs, however, many expressed limited understanding of ED presentations, symptoms, and detection. Moreover, some even endorsed common ED stereotypes, such as “either you're throwing up in a bathroom or you're eating a lot” (Transcript 5). Thus, it may be particularly important to target both parents and their children when creating ED psychoeducational materials for this population.

**Barriers to EDs Treatment: Lack of South Asian representation.** Across focus groups, participants expressed awareness of the lack of representation of South Asians in multiple domains, including media portrayals, clinical trials, research, and the mental health field – both as patients and providers. As a result, many South Asian women in the United States feel silenced, are more likely to negate or dismiss their ED experiences, and feel marginalized across settings.

I feel like underrepresentation is also a big thing because if you don’t see people that are like you I guess, feeling depressed, that had anxiety like you, [then you think] ‘why am I like that, I shouldn’t be like that.’ So, you don’t feel the need to get diagnosed or tell your

parents because you just feel like it shouldn't be like that or I shouldn't be like that.

Because you don't see people that are like you like *that*. (Transcript 5)

Importantly, within the healthcare realm, participants noted that South Asians are rarely highlighted in mental health campaigns and are thus less likely to have access to treatment and support for their ED and other concerns. Furthermore, because South Asians are rarely included in research samples (and analogous to their parents' distrust about Western medicine) participants were less likely to trust medical findings because they were considered inconclusive and ungeneralizable to these communities. For instance:

I guess, scientifically most of the times, I'm skeptical because most of the clinical trials are done on Caucasians, so I'm not too sure – especially for more complex disorders – that the medicine [the doctor] is giving me is going to be that effective on me just because there's no supportive data with Asian or South Asian people. (Transcript 1)

Lastly, in reference to EDs specifically, participants stated that while they knew that based on personal experience, South Asians are less likely to report serious mental health conditions due to social and generalized stigma, they felt that this fact was not fully acknowledged in the current literature:

P1: I think I once heard, that I guess South Asian peop- like a statistic on South Asian people that have, like there are fewer South Asian people or [a] fewer percentage that have eating disorders, but I wonder how much of that is just, under-diagnosis, and just not acknowledged, and like not acknowledging it.

P2: We talked about that too about prevalence, and it's like, a lot of it with depression and you know stuff like tha – like especially men – they won't feel comfortable expressing

their silent feelings about stuff so it's underrepresented.

P1: Yeah and underreported 'cuz people don't feel comfortable sharing. (Transcript 5)

**Barriers to EDs Treatment: Healthcare provider bias.** In addition to internal barriers imposed by South Asian cultural norms and practices surrounding mental health, many participants reported difficulties seeking care and validation from their healthcare providers. They repeatedly described negative experiences in which their medical providers were (1) dismissive, (2) culturally-insensitive, and/or (3) fat-shaming, regardless of whether they were seeking care for a physical health condition, a mental health condition, or an ED specifically. The main concerns that participants described were distilled to two concepts: communication barriers with primary care providers (PCPs) and “it’s culture.”

First, many participants described experiences in which their PCPs were dismissive of their symptoms and experiences or even engaged in weight stigma. As a result, they had to self-advocate for themselves and/or a family member to receive care.

I feel like for health professionals, I feel they should just be more sensitive and realize that there’s a lot of different cultures coming in and everyone reacts to things differently, and there’s ways that you can talk to certain types of people and you can’t just... ’cuz I’ve definitely been in situations where my mom will go to the hospital and they didn’t take her seriously...they’ll just assume we’re being too dramatic – people from other countries – and then they won’t understand them properly...it just made me wonder, ‘oh, if she was White or something, they understood her, would they take her more seriously?’

(Transcript 2)



Next, participants reported that when they presented for care, many PCPs attributed their symptoms to their cultural background. Often, providers would make assumptions based on the intersectionality of the participant's identities as both a woman and a person of color.

Every time I brought something up, my PCP was very quick to be like, 'it's culture.' But you don't know anything about the culture though so, you can't – like if you looked at it, then maybe we could have a real discussion. Don't assume that we're not going through it just 'cuz you don't know anything about it kind-of-thing. (Transcript 1)

Considering the particular difficulties associated with South Asian American women seeking treatment for a mental health condition, including an ED, participants described how it was doubly frustrating when, after surmounting cultural difficulties, they encountered culturally-insensitive health providers who made them feel worse about their concern, rather than helping them address it.

I think something that professionals should know is that it just takes a lot from a South Asian women to just actually know, and just tell someone about their problems. 'Cuz sometimes people in their family aren't understanding, like they don't really have a support system. So, for them to like take that step by themselves – it's a big enough deal without really like scaring them like, 'oh my god you're – there's something wrong with you!' (Transcript 6)

Three major themes emerged regarding potential facilitators of EDs treatment, including: intergenerational conversations about mental health, basic psychoeducation/health campaigns about EDs, and cultural sensitivity training for healthcare providers. Each of these themes is described in more detail below.

**Facilitators of EDs Treatment: Intergenerational conversations about mental health.** As a solution to the “stigma” and “parents’ mental health” barriers, participants recommended that mental health providers target older generations by providing basic psychoeducation about mental health and EDs and work towards de-stigmatizing these issues. Further, participants suggested that mental health providers facilitate intergenerational conversations between parents and their children in order to offer parents the opportunity to process any unresolved stressors, while simultaneously supporting their children’s mental health. Some focus groups expressed optimism for the future and added that their generation could help shift the conversation towards mental health advocacy by challenging mental health stigma within the South Asian community; however, many acknowledged that this shift could not take hold without acceptance by their parents’ generation:

And I think fixing this problem is gonna take a long time because it’s a generational issue. And you have to *break* this like concept of (inaudible). And that’s gonna take a long time. But I think to facilitate what you’re saying – yeah outreach and like education – and if our moms and dads are always on Facebook, give them *accurate* information on Facebook and not something like random (inaudible). So, catering to something that you know that they’ll pay attention to and they’ll receive positively. And yeah I guess trying to break the stigma somehow, but I don’t know how... Yeah that’s where the generational difference happens. Like us, like yeah we’ll be there for our family people and we’ll break this chain, but at the end of the day, our parents still have authority so you can try to help the kids so much, but when mom, dad, grandma, aunt, and uncle are doing the same thing, the change has to come from them as well... (Transcript 3)

Additionally, it is important to note that although most participants reported difficulties confiding in their parents, a minority noted that their parents were willing and open to having conversations about emotional distress and mental health concerns. Participants who felt under-supported at home reported confiding in fellow South Asian peers experiencing similar struggles.

**Facilitators of EDs Treatment: Basic psychoeducation/health campaigns about EDs.**

Psychoeducation was one of the most common recommendations that participants gave to help facilitate ED treatment uptake. If possible, they suggested that South Asian-identified doctors be trained to disseminate this information to local South Asian communities as a means of easing any initial discomfort for community members and building trust. One participant went further by providing additional recommendations for the types of information that doctors could teach to community members, such as presenting statistics and emphasizing the physical symptoms and outcomes of EDs:

I think persistence is one thing, ‘cuz it’s hard to get it through tradition and blood, and what we’ve been trained to think. So, I feel like it’s just slowly kind of breaking down that wall and slowly being like, ‘this is the education, this is the research.’ Presenting a lot of evidence is usually a good thing. I think we love numbers and the fact that we can see [the] concrete effects of it. (Transcript 4)

**Facilitators of EDs Treatment: Cultural sensitivity training for healthcare**

**providers.** Lastly to combat the deleterious effects of the “healthcare provider bias,” participants recommended that more care be taken to educate general practitioners about the etiology and symptoms of EDs. Participants remarked upon how many of their health providers did not appear to be trained in detecting EDs during routine medical visits. This was especially concerning to participants, given that they knew they could provide false responses on questions asking about

nutrition, exercise, and eating habits. Furthermore, they noticed that when they were asked directly about any potential history with an ED, they could easily answer “no” without any follow-up or open-ended questions. In addition, participants made concrete suggestions regarding ways in which adolescent health providers, such as pediatricians, could be more proactive about educating South Asian parents and children about EDs and body image.

However, pediatricians should opt to strike a balance between acknowledging the adolescents’ autonomy by ensuring that all conversations directed towards parents are also explained in a way that includes the child in her own healthcare. Furthermore, participants suggested providers ask parents to step out during examinations, providing an opportunity for a more confidential ED assessment. Many participants described feeling uncomfortable openly discussing their concerns with providers, as their parents were often present in the examination room. For instance:

The biggest problem for me was when I was younger, my parents would be in the room with me and my doctor would talk to them – or would like mainly talk to them about the issues I was facing – and they obviously have their own version of what, or they obviously have their own opinion of everything I’m facing. So, it would just be a one-sided conversation and I wouldn’t have any input. (Transcript 1)

Lastly, participants reported that it was essential for providers to receive cultural-sensitivity training that could help them facilitate more inclusive conversations with patients, as well as anticipate potential cultural differences in symptom presentations. Specifically, rather than making assumptions about a client’s presenting concerns and attributing them to her cultural background, South Asian American women want their doctors to be willing to do their own research and be open to discussing findings from this lens with patients. As one participant illustrated:

Yeah, I don't want things [to be] assumed. But a lot of the times it *is* because of cultural factors, but I don't want to be the one doing the explaining. Like, 'I'm here to get help, I'm paying for this. I'm not paying to give you a lecture.' (Transcript 1)

Furthermore, participants noted that they felt invalidated when their health providers did not take EDs seriously or acknowledge their existence. Because South Asian American women often feel denied within their community, it is that much more important for their providers to serve as advocates and allies in the treatment process:

And for psychology, it is very cultural-specific. We have different symptoms that we need to identify and having psychologists and having awareness is *so* important and even as a personal struggle, growing up, you don't realize you *have* symptoms of these illnesses because you're told you can't have it. Like it's not possible. (Transcript 3)

### **Discussion**

Though it is known that EDs affect individuals of all racial/ethnic backgrounds (Cheng et al., 2019), people of color tend to be overlooked in the ED literature. South Asian Americans, a specific subset of individuals traditionally categorized within the larger umbrella group of "Asians," have been notoriously neglected in both the broader mental health literature, as well as in the ED literature (Inman et al., 2014; Iyer & Haslam, 2003, 2006). Currently, very little information exists on the etiology and presentation of EDs amongst these communities. Even less is known about culturally-specific barriers to treatment-seeking for this population. To begin to address both of these issues, this study used focus group methodology with South Asian American women to identify salient themes.

Studies addressing these topics within South Asian American samples are especially needed given that only three peer-reviewed studies to date have been published on this subject

(i.e., Chang, Perera, & Kupfermann, 2014; Iyer & Haslam, 2003; Reddy & Crowther, 2007). To inform future studies aimed at promoting prevention and treatment efforts amongst this population, including culturally-sensitive ED survey development specific to South Asian communities, it is imperative to establish a baseline level of knowledge concerning EDs within this group. Without first identifying gaps in our understanding of this phenomenon, such as culturally-salient factors that could be uniquely contributing to ED pathology for this group, it is virtually impossible to address this issue adequately. Thus, by necessity, the current study was exploratory in nature and utilized a qualitative design to achieve its aims.

Thematic analysis of the seven focus group transcripts revealed significant themes for each domain (i.e., body image, EDs, barriers to treatment, facilitators of treatment) that both confirm, extend, and enhance past research with other South Asian communities. A summary of findings and implications for each domain is presented in the following paragraphs.

### *Body Image*

Focus group data revealed multiple paradoxes that South Asian American women are subjected to regarding body and appearance-related ideals. For instance, participants described that they are expected to appear and act a certain way in preparation for marriage, however, they are simultaneously unable to date or mingle with men in most other contexts. Furthermore, given cultural norms surrounding food, including the importance of accepting offerings of additional helpings as a form of respect, many women described a double difficulty of both eating more food than they physically felt comfortable eating in a sitting, followed by comments that they were becoming too big or fat. It appears that South Asian American woman are expected to possess a body shape that maps onto a very narrow, and poorly defined, middle point on a metaphoric scale that is anchored by the thin ideal on one end and the “healthy” ideal on the

other. This makes it especially difficult for South Asian women to determine what the actual “ideal” woman should weigh.

Therefore, although these findings support more recent studies suggesting that thinness carries some social value or capital in South Asian culture (Gandhi et al. 1991; Perera et al., 2002), they also seem to support the notion that thinness is not the only appearance ideal to which South Asian women are subjected. Moreover, these results suggest that the thin ideal might not be relevant for South Asian women in the same way that it is for other cultural groups, such as White women. For instance, many participants described that although the thin ideal is generally the standard for South Asian women, any woman deemed “too thin,” was immediately expected to resolve this issue by aligning herself more closely with the “healthy” ideal, which calls for a more curvy, plump body type. This might also help to explain why numerous studies have found that South Asian adolescents with ED symptoms have presented without expressing a desire to lose weight or appear thin (Bhadrinath, 1990; Bhugra & Bhui, 2003; Khandelwal et al., 1995; Tareen et al., 2005).

Importantly, in contrast to South Asian women living on the Indian subcontinent or perhaps in other countries in the diaspora, the current study identified a unique dual appearance pressure that South Asian women experience as a result of living and growing up in the United States, with a White majority group. Specifically, many participants described difficulties reconciling changing beauty norms associated with American culture (e.g., curvier, thicker body, tan skin) and more standardized South Asian beauty norms (e.g., Eurocentric ideal, thinner physique, lighter skin). To navigate this divide, women described having to essentially code switch, assimilating more with White, American culture when they were at school, for instance, and reverting back to more traditional South Asian standards of beauty when at home or with

other community members. Similar struggles reconciling multiple appearance pressures have been documented in other collectivistic groups living in the United States (Patton, 2006; Perez, Ohrt, & Hoek, 2016). Thus, clinicians should take special care to discuss differing appearance and cultural ideals with South Asian American female clients and possibly utilize therapeutic orientations, such as feminist theory and multicultural frameworks (Tummala-Narra, 2013), that address the role of sociocultural forces in shaping an individual's sense of herself, including her body image. Furthermore, perhaps the protective factors participants described, including ethnic pride and rejection of all beauty ideals, can be leveraged against the internalization of other body- and ED-risk factors for South Asian American women.

In addition to body shape ideals, it was evident across focus groups that South Asian American women are expected to possess lighter skin, and that women with darker skin are advised to remedy this situation by using homemade concoctions or purchase products to lighten and enhance their skin (e.g., *Fair & Lovely*). Many participants understood the potential physical harms associated with using such bleaching creams and rejected the notions associated with colorism. However, they also acknowledged that colorism was still prevalent in the United States, despite the presence of other racial groups that are both physically lighter and darker than South Asian communities. Participants described how they believed that colorism was a remnant of colonization and agreed that South Asians had internalized a desire to be *White*, and skin tone was only one example of this.

These data are consistent with other research, which has posited that the skin lightening behaviors among South Asians on the Indian subcontinent are symptomatic of the larger, more complex problem of White supremacy (Hall, 2013). Thus, understanding the broader context of colorism within the South Asian community might help to elucidate understanding not only of



the presence of, but also, the ubiquity and negative impact of the light-skin ideal within this group. Furthermore, participants differentiated between a dynamic, ever-changing American beauty ideal and the relatively more rigid South Asian beauty ideal by asserting that the latter is more closely aligned with a Eurocentric ideal of beauty, which prioritizes more standard elements of Whiteness, including both lighter skin (relative to South Asians) and thinner body shapes for women.

Thus, it appears that both the findings related to the presence of a thin ideal of beauty for South Asian women, and the colorism ideal might reflect a greater cultural desire for Whiteness. This study lends additional support to prior research arguing that a desire for lighter skin should be considered a culturally-relevant and salient factor for South Asian women when assessing for body image and ED concerns (Bhagwat, 2012; Furnham & Patel, 1994; Sahay & Piran, 1997). Past research with Asian American women has documented how irreconcilable contrasts between the physical attributes associated with the Eurocentric ideal and the skin tone of most Asian women, can result in higher rates of body dissatisfaction for this broader group (Mintz & Kashubeck, 1999; Yokoyama, 2008; Yu et al., 2019). Thus, it stands to reason that the same trend may apply for South Asian American women. Clinicians should be open to discussing and addressing this discrepancy for South Asian American women presenting for services.

Lastly, participants described how many of the beauty and appearance ideals to which South Asian American women were subjected related to marriage pressures. Marriage appears to be a core motivator around which all ideals and values associated with a South Asian woman are based. Women feel pressured to possess qualities associated with the South Asian female ideal (e.g., light skin, virgin, long hair, no body hair, thin body) because these characteristics are viewed as making her optimally desirable to a suitable *Desi* man. Marriages, and by extension,

South Asian female beauty features, are seen as transactional and a means to an end. Thus, appearance pressures young women experience from family members could reflect older individuals' fears that their young female relatives might not be able to attract and marry a respectable *Desi* man, which in turn, may affect their overall economic and social stability. Many South Asian American young women disagreed with this pressure and reported that they had other priorities, such as their careers. However, they noted that this pressure was both ubiquitous and inescapable. Overall, considering that the pressures associated with marriage could lead to unhealthy behaviors, such as using potentially harmful skin lighteners (Russell-Cole et al., 2013), and engaging in maladaptive eating and weight control strategies (Hoque, 2011; Suhail & Nisa, 2002), it is imperative that clinicians and researchers acknowledge this cultural context and discuss expectations surrounding marriage with South Asian American patients with body image and/or ED concerns. Additionally, clinicians could explore how marriage pressures and gender disparities in body image expectations are tied to South Asian femininity and gender role identity within this cultural context (Tummala-Narra, 2013).

### *Eating Disorders*

One of the most important themes that emerged in regard to ED concerns was participants' description of how older South Asian women, including mothers, relatives, and *aunties*, prioritized weight above all other indices of beauty. They would use negative, blunt comments and surveil younger women's food intake to enforce this standard. Weight stigma has been well-documented in both non-South Asian and South Asian populations (Agrawal et al., 2015; Ambwani et al., 2015; Kersbergen & Robinson, 2019). In fact, women were expected to adhere to this standard, regardless of whether they were physically able to or not. For instance, women's weight and body shape were critiqued even when they were known to have medical

illnesses directly affecting weight status, such as diabetes or thyroid irregularities. Indeed, rates of diabetes in particular are elevated amongst South Asian communities living in the United States (Kanaya et al., 2010; Shah, Vittinghoff, Kandula, Srivastava, & Kanaya, 2015); thus, health professionals should consider assessing for these comorbid health conditions during intake. The current study extended this work by noting, not only how pervasive and disproportionate weight stigma is for South Asian American women relative to men, but also how weight, weight stigma, and body discrimination, are central to understanding EDs in South Asian American women.

As noted above, weight maintenance is important for marriage, both in acquiring and keeping a respectable suitor. Moreover, participants described that women are not only expected to look thin and control their diet to attract a suitor, but are also expected to maintain this standard throughout marriage – regardless of their husbands’ weight-related behaviors. Thus, to keep younger women in compliance with these expectations, it appears that negative comments and food monitoring are expected and normalized. Furthermore, younger women are unable to combat these comments due to expectations surrounding obedience and filial piety. In addition, this criticism is pervasive, as cultural norms allow all women, including community women (*aunties*) and relatives, free license to make comments about other people’s daughters. These findings align with past research documenting high rates of body discrimination and body dissatisfaction (especially for women in larger bodies), and help to clarify the social fear of fatness pervasive in this population (Agrawal et al., 2015; Ambwani et al., 2015; Chugh & Puri, 2001; De & Chakraborty, 2015; Stigler et al., 2011). In sum, considering how negative appearance-related comments by family members, especially parents, can contribute to disordered eating and body dissatisfaction in women (Rodgers, Paxton, & Chabrol, 2009; Taylor

et al., 2006), South Asian American women might be particularly vulnerable to eating pathology. Interventions tailored for this population should focus on mitigating the deleterious effects of appearance-based comments by family members, and aim to target older women as they appear to be the most influential figures in terms of socializing younger women by perpetuating these beauty ideals.

Similarly, women described experiencing social pressures from multiple sources, including community members, extended family, and peers, to uphold appearance standards. Similar to methods used to enforce weight standards, women reported also receiving comments about other facets of their appearance, such as the presence of body hair or their skin tone. In addition to criticizing these features, commentators offered unsolicited recommendations to remedy these perceived imperfections, which were often in the form of pseudo health tips. These social pressures and comments are concerning, especially since many participants described how they internalized this frequent and consistent feedback. Further, several women noted that it led them to doubt their confidence and body esteem. Thus, it appears that South Asian American women are stuck in a double bind in which they experience negative comments about multiple facets of their physical appearance, and yet, are unable to self-advocate due to cultural expectations surrounding gender roles and filial piety.

In addition to these social pressures, it is important to note that women described how their parents in particular had high expectations of them, especially in terms of their appearance and academic achievement. Consistent with past findings (Chang, Perera, & Kupfermann, 2014; Gupta et al., 2011; Inman et al., 2014), pressures associated with the model minority stereotype, specifically the academic achievement standard and discriminatory assumptions associated with this stereotype (e.g., “all Indians are smart”), appeared to be associated with body image and ED

concerns. In the current study, women described how these pressures were experienced as a need to maintain perfection in every facet of their life, citing both high *parental* expectations and pressures to maintain these standards, as well as high *personal* pressures to maintain a certain level of perfectionism. Other women of color, such as Black and Latina women, describe a similar “Superwoman” pressure, in which they tend to sacrifice their own needs (including mental health and emotional needs) to protect their families (Miville & Ferguson, 2014; Woods-Giscombe, 2010). Moreover, the “Superwoman ideal” has been identified more broadly as an important correlate of eating psychopathology in other adolescent and college women samples (Crago, Yates, Fleischer, Segerstrom, & Gray, 1996; Hart & Kenny, 1997; Mensinger, Bonifazi, & LaRosa, 2007). Given that perfectionism (both self-oriented and parent-oriented) is a robust risk factor for EDs (Bardone-Cone et al., 2007; Goel et al., 2019; Lilenfeld et al., 2006), it seems especially important to assess these factors in South Asian Americans presenting for treatment.

Women also described several experiences of racial discrimination that might be especially relevant to EDs amongst South Asian American women. Specifically, they noted that racial discrimination, teasing about certain ethnic features, and experiences of being the token South Asian in a room full of White peers, impacted their self-esteem and elicited a desire to assimilate into White, American culture. Similar findings regarding the relations between disordered eating and difficulties with assimilation and experiences of racial teasing, respectively, have been reported by other South Asian communities both in the United Kingdom and United States (Mumford et al., 1991; Reddy & Crowther, 2007). Although racial discrimination and prejudice is an unfortunate common occurrence for marginalized groups within the United States, notably, some participants described a particular type of xenophobia tied to anti-Muslim and anti-terrorism sentiments as a result of the attacks on 9/11. This is

especially important considering that racial discrimination and internalized racism are correlates of eating pathology in other cultural groups (Gilbert, 2003). Moreover, anti-terrorist xenophobia is a unique form of racism directed at South Asian communities living in the United States (Inman et al., 2014; Tummala-Narra et al., 2011). Thus, future research should aim to enhance understanding of how race-related discrimination might contribute to EDs in South Asian American women.

Lastly, similar to other studies conducted with South Asian communities (Bryant-Waugh & Lask, 1991; Inman et al., 2001; Inman, 2006; Javier, 2017; Mustafa, 2013; Reddy & Crowther, 2007), cultural conflict, specifically, a clash between traditional collectivistic values upheld by parents and more individualistic, American values upheld by South Asian children, appears to be particularly salient for South Asian American women. Many women described difficulty straddling two cultures with differing values, often feeling either “too American,” or “too Indian (or South Asian),” for both their White, American peers and their South Asian families and communities; however, they never felt fully whole or complete in either identity. This phenomenon has been labeled as the “American-born Confused Desi” (ABCD; Shankar, 2008) syndrome to capture the identity crisis that many first-generation South Asian Americans face when attempting to negotiate multiple cultural boundaries. This conflict is noted as a cultural factor impacting eating pathology in other Asian American groups (Yu et al., 2019). Thus, it could be integrated into therapy work with South Asian American clients. For instance, clinicians could utilize techniques from dialectical-behavioral therapy (Chen et al., 2014; Telch, Agras, & Linehan, 2001) to enhance skills related to the duality inherent in occupying multiple worlds. In addition, future quantitative research should focus on testing whether this phenomenon is a cultural correlate of eating pathology for this group.

*Barriers and Facilitators of Eating Disorder Treatment*

Whilst coding the data, it became evident that it was difficult to disentangle discussions about mental health more broadly from EDs more specifically – it appeared that for participants, the perceptions that they and other community members had could only be interpreted within the greater context of mental health stigma within this population. As a result, many of the barriers that they highlighted applied to both their understanding of different mental health concerns, such as anxiety, depression, and suicide, along with EDs. In line with past work with South Asian communities (Arora et al., 2016; Chaudhry & Chen, 2018; Fountain & Hicks, 2010; Inman et al., 2014), stigma surrounding mental health was identified as a potent barrier to treatment-seeking. In the current study, findings indicate that this community experiences both a general and social form of stigma surrounding mental health. For South Asians, it appears that this social stigma tied to a fear of judgement by fellow community members, and subsequent shame, may be reinforcing a culture of silence surrounding mental health concerns (Wales et al., 2017). This is understandable considering that interpersonal relationships are especially valued in interdependent, collectivistic cultural groups (Markus & Kitayama, 2010). Thus, any actions committed by or affecting one individual might be perceived as a reflection on an entire social network. This is especially true for South Asian American women, who described how their parents feared that if others in the community were to find out that they or their children were experiencing mental illness, their family's overall social reputation and standing within the greater South Asian community would be tarnished.

Thus, to mitigate the consequences associated with this social silencing, participants provided recommendations for facilitating help-seeking behaviors by creating spaces in which parents and their children could engage in productive conversations that are grounded in

scientific, evidence-based knowledge about mental health. These conversations could also provide an opportunity for honest dialogue between generations about topics such as parental expectations and feedback. Additionally, this education could focus on providing parents with tools to support their children's development, especially in regard to ED prevention and treatment (Le Grange, Lock, Loeb, & Nicholls, 2010). Further, this experience might help parents address their own potential untreated "trauma" (as described by participants) related to immigrating and acculturating to the United States. This might be especially important considering that immigration trauma tends to permeate throughout a family system, impacting all individual members both directly and indirectly. Thus, providing additional support and even potentially using strategies from a structural family therapy approach could benefit both parents and their children (Beckerman & Corbett, 2008). Ideally, based on feedback from these focus group participants, this forum would be moderated by South Asian health professionals. Overall, it appears especially important that health providers work collaboratively with community members to facilitate intergenerational conversations about mental health with the hopes that these conversations can encourage South Asian American women to seek treatment for an ED or any other mental health concern.

In addition to providing general knowledge about mental health, providers could facilitate ED-treatment seeking by conducting community-based psychoeducational campaigns that describe the etiology and prevalence of EDs. Considering that many cultural groups, including South Asians, might doubt the existence of EDs in their respective cultural group (Perez & Warren, 2013), it is imperative that providers emphasize that EDs can affect people of all racial/ethnic groups (Cheng et al., 2019). Furthermore, it would be important to include culturally-tailored information highlighting how EDs might present differently across groups. In



addition, clinicians can culturally adapt methods that have worked with other marginalized groups, such as emphasizing the physical and medical complications associated with EDs (Yu et al., 2019) and genetic risk factors for EDs (Striegel-Moore & Bulik, 2007) to appeal to the fact that currently, South Asians prioritize physical over mental health.

Additionally, given the frequency with which participants described instances of parental self-blame, health providers could also emphasize the multifaceted etiology of EDs, noting that many factors (most prominently biological ones) contribute to the onset of EDs (Mazzeo & Bulik, 2009; Striegel-Moore & Bulik, 2007). Furthermore, clinicians should emphasize how parents are essential allies in recovery, rather than targets of blame (Le Grange et al., 2010). Considering that participants described how both their parents' generation, and their own, were unaware of how to detect ED symptoms, health providers could include this information in pamphlets and also provide culturally-specific resources (e.g., names of South Asian providers and local ED clinics) that redirect individuals to services. Furthermore, consistent with best practices for community-engaged research (George et al., 2014; Wallerstein & Duran, 2010), health providers could partner with community leaders associated with local gathering spaces, such as religious temples, to gain credibility and trust. Overall, finding ways to make ED psychoeducation easily accessible and disseminated is key to demystifying these conditions and facilitating treatment uptake for this population.

Lastly, in addition to educating South Asian parents and children about the importance of vigilance about mental health and EDs, participants identified health providers as key perpetrators of weight stigma and barriers to treatment-seeking behaviors. Indeed, research has demonstrated that health providers are susceptible to biases that limit their recognition of EDs in non-White racial groups (Abbas et al., 2010; Alegria et al., 2002; Becker et al., 2003; Marques et

al., 2011). These biases appear to contribute to racial and ethnic disparities in ED treatment referrals and diagnoses. In addition, general practitioners and PCPs are rarely trained in ED detection, which is especially problematic, as most patients with EDs first present to their PCPs for treatment (Button et al., 1998; Dickerson et al., 2011; Striegel-Moore et al., 2008; Walsh et al., 2000). Again, to combat these treatment barriers, participants provided the following concrete suggestions: (1) ensure that health providers receive global cultural-sensitivity training, along with (2) general training about ED assessment and symptom presentations.

In regard to the first recommendation, participants described how, in preparation for a session or appointment with a patient, health providers could read articles about different cultural considerations for South Asians, and rather than assuming that these cultural factors are necessarily accounting for a patient's presentation, be open to dialogue with the client and consider alternative explanations. Additionally, for ED treatment specifically, health providers could ask parents to step out of the examination room to enhance privacy and confidentiality when assessing EDs in South Asian children. Furthermore, providers should take better care to acknowledge the pediatric patient's autonomy and engage her in taking responsibility for her own healthcare. Although few, if any, evidence-based prevention and treatments for EDs designed specifically for people of color exist (Perez, Ramirez, & Trujillo-Chivacuan, 2019; Reyes-Rodriguez & Bulik, 2010; Taylor, Fitzsimmons-Craft, & Goel, 2018), practitioners can employ culturally-sensitive strategies by screening for factors relevant for South Asian American women, such as assessing parent-oriented perfectionism, discrimination and related stressors, and preference for lighter skin, in addition to assessing for the core diagnostic features of EDs. To merge these two recommendations together, participants also emphasized the importance of healthcare providers accounting for the fact that many South Asian families' diets consist of

ethnic-specific cuisines that differ from normative American foods; thus, nutrition advice based on Western-normative foods, for instance, is rarely applicable to many South Asian patients. In sum, basic psychoeducation about EDs for both health providers and South Asian communities is warranted.

### *Strengths and Limitations*

The current study utilized focus group methodology to enhance understanding of the ways in which South Asian American women discuss and conceptualize body image and ED concerns, as well as identify potential barriers and facilitators to ED treatment. Although there were many strengths of the current investigation (e.g., qualitative method design to facilitate culturally-sensitive research [Hughes & DuMont, 1993], and over-recruitment of a traditionally underrepresented group), findings should be interpreted within the context of certain limitations.

Contrary to expectations guided by past research (George et al., 2014), recruitment for the current study was not especially difficult; indeed, the principal investigator was forced to turn away additional potential participants due to time, financial, and saturation constraints. Although these findings are encouraging, it is important to note that the high incentive may have bolstered participation rates in the current study. Additionally, this study recruited women exclusively.

Future research should aim to replicate findings with South Asian men and other gender groups to identify possible differences and similarities in appearance-related and ED pressures.

Although there was ethnic diversity in the current sample, no participants from the Maldives or Bhutan were represented. Furthermore, given the dearth of data on other South Asian sub-groups, the literature review that informed the current study was primarily focused on Indian and Pakistani samples. Taken collectively, findings might not generalize to these specific populations. Next, although qualitative investigations are especially helpful in elucidating

phenomena among underrepresented groups, they are limited in their generalizability due to typically small sample sizes. Additionally, given that the principal investigator served as both the developer of the semi-structured interview guide and moderator of all focus groups, there might be some undue research bias that influenced the interpretations and major themes that arose from the study data. Further, due to the inherent limitations imposed by qualitative study designs, the relative strengths and associations between factors cannot be determined without use of statistical methods. Thus, future quantitative work should evaluate whether the culturally-salient factors identified in the current study are associated with eating pathology for this group. Additionally, longitudinal data can help to identify possible ED risk factors for this group. Considering that the current sample was non-clinical, identified barriers and facilitators of treatment were based on participants' perceptions rather than personal experience with an ED; thus, future work should aim to replicate these findings with clinical samples to determine whether additional factors also apply.

Unprompted, many participants used case studies of peers in their South Asian communities who had committed suicide to illustrate their parents' denial and lack of understanding about the seriousness of mental health concerns. However, because the current investigation primarily focused on EDs and related behaviors, the principal investigator was unable to explore this topic further with participants. Indeed, suicide rates appear to be relatively high in young South Asian women (Bhugra & Desai, 2002); however, suicide may be a largely untreated issue in the community and might go unreported due to social stigma. Considering the seriousness of suicide coupled with the silencing effects of stigma, future work should aim to investigate this further. Lastly, a history effect might be present in this dataset, as this investigation was conducted during the 2018-2019 academic school year, a time when the

political climate in the United States was particularly focused on immigration policies. This cultural context could have affected participants' responses by potentially making perceptions of immigration trauma more salient.

### **Conclusions**

In sum, the current study aimed to contribute to the literature by enhancing understanding of the ways in which South Asian American women conceptualize and discuss body image and EDs. Considering the limited amount of data on this topic, qualitative investigations like the current one are crucial to informing clinical prevention and treatment efforts with this underserved population. Given that most current knowledge about EDs in South Asians is based on ED instruments normed on Western samples and using Western-oriented diagnostic criteria (Cummins et al., 2005; Khandelwal et al., 1995; King & Bhugra, 1989; Nasser, 1998; Sue et al., 2012), the primary goal of the current study was to perform an exploratory analysis to gain a baseline understanding of the conceptualization of body image and ED concerns within this group. Results of this study can inform future ED survey development to ensure accurate assessment of ED pathology among South Asian communities.

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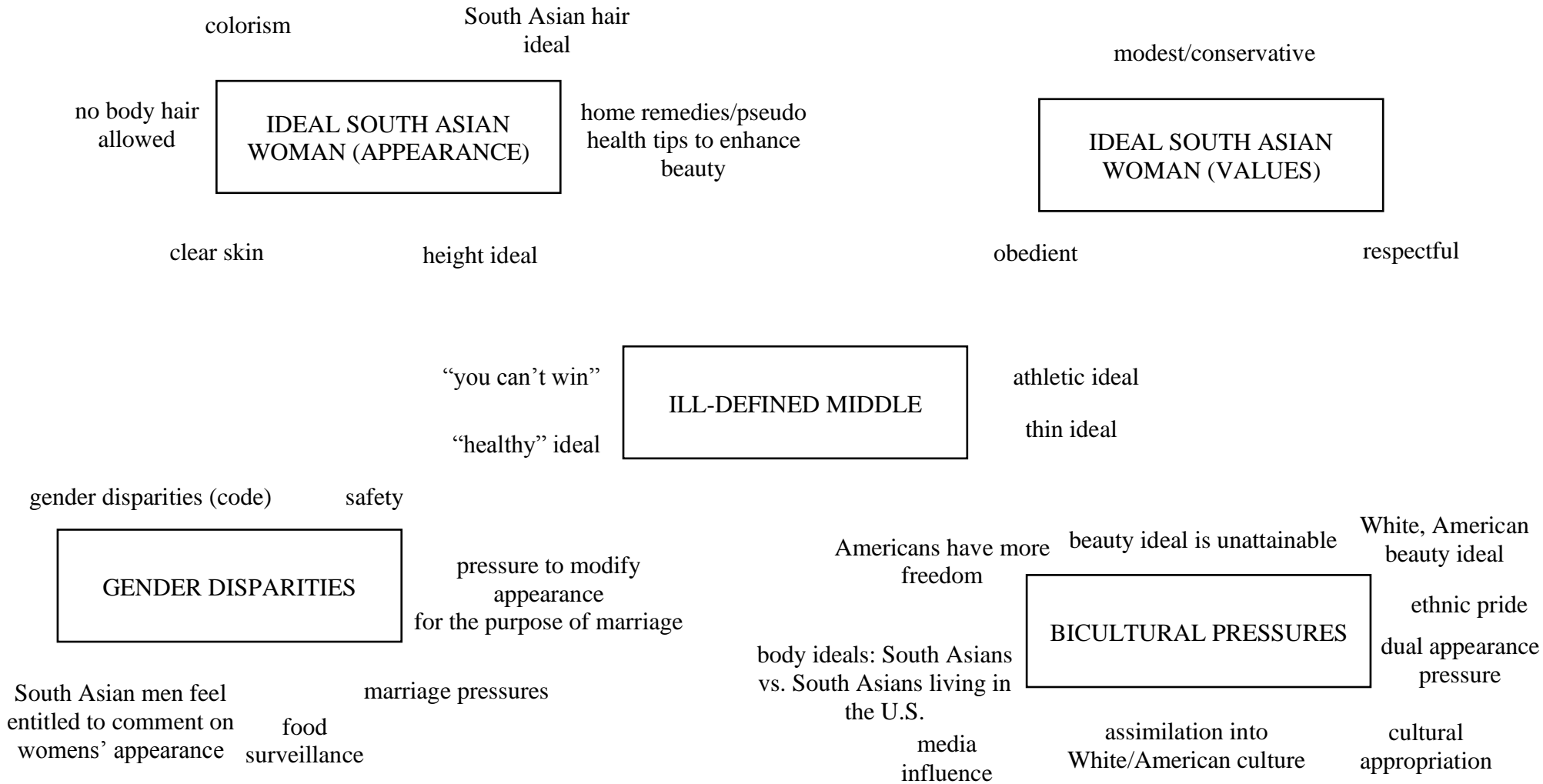


Figure 1. Thematic map for body image, displaying five major themes and their associated codes.

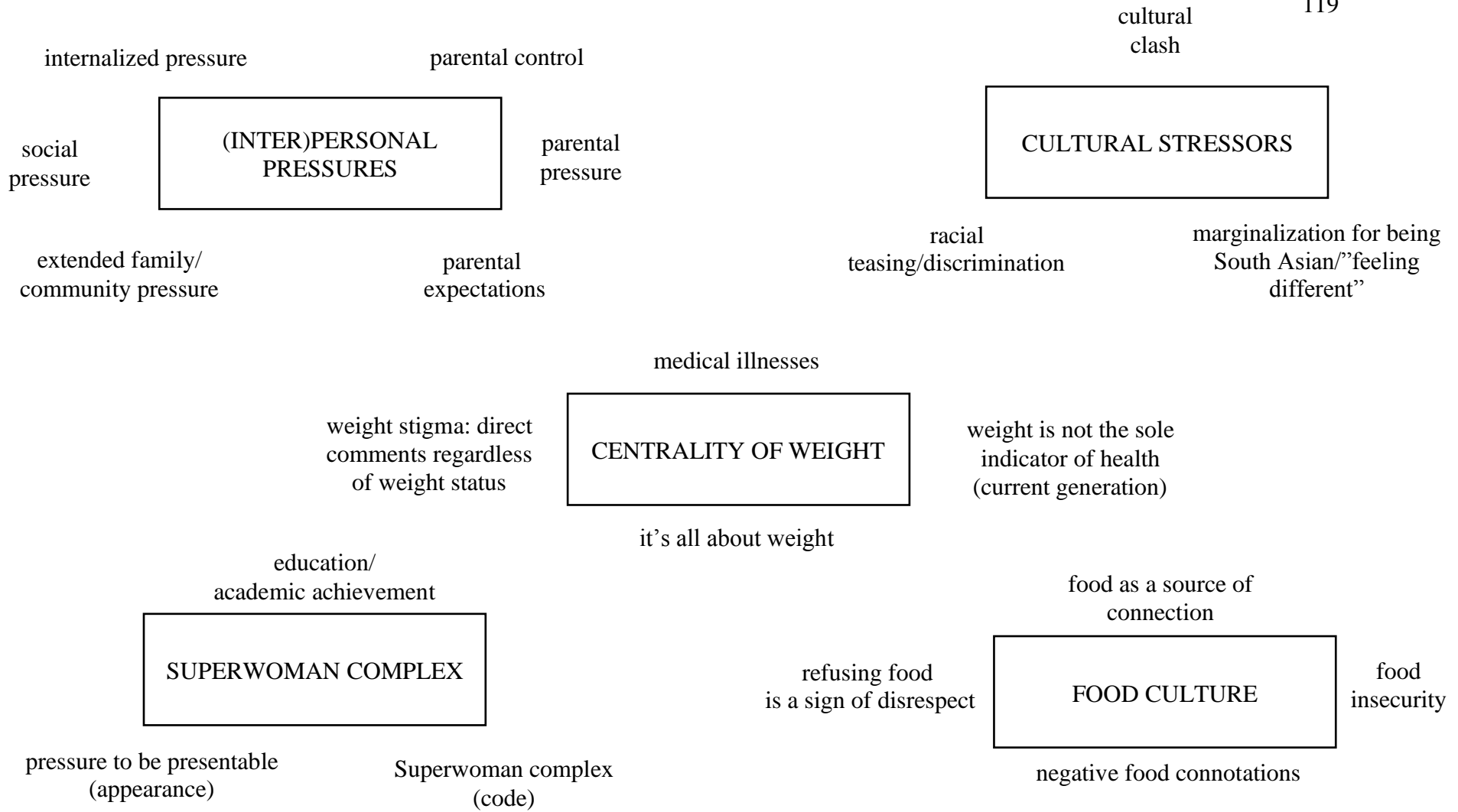


Figure 2. Thematic map for eating disorders, displaying five major themes and their associated codes.

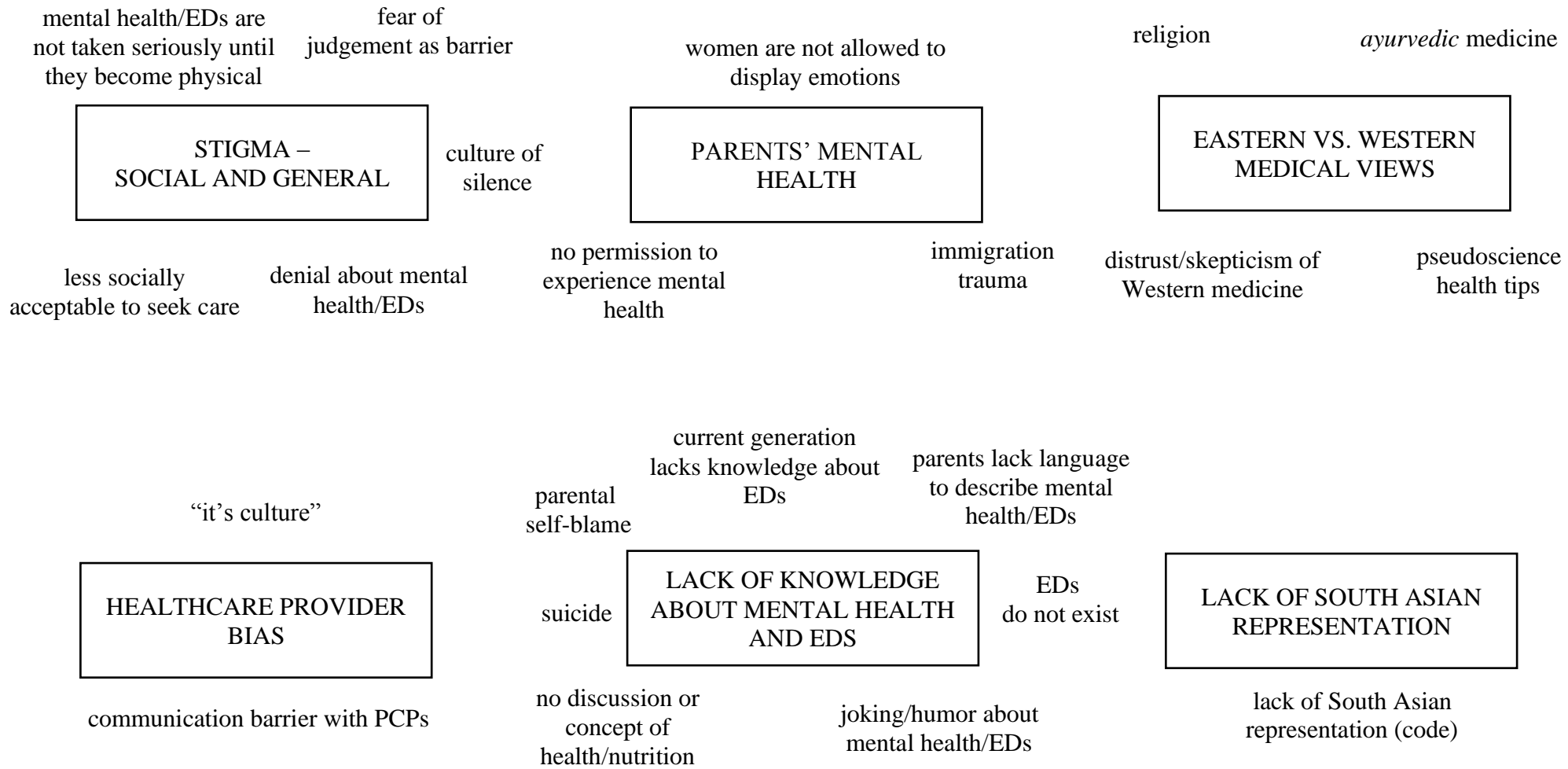


Figure 3. Thematic map for barriers to seeking eating disorders treatment, displaying six major themes and their associated codes.  
 Note. EDs = eating disorders.

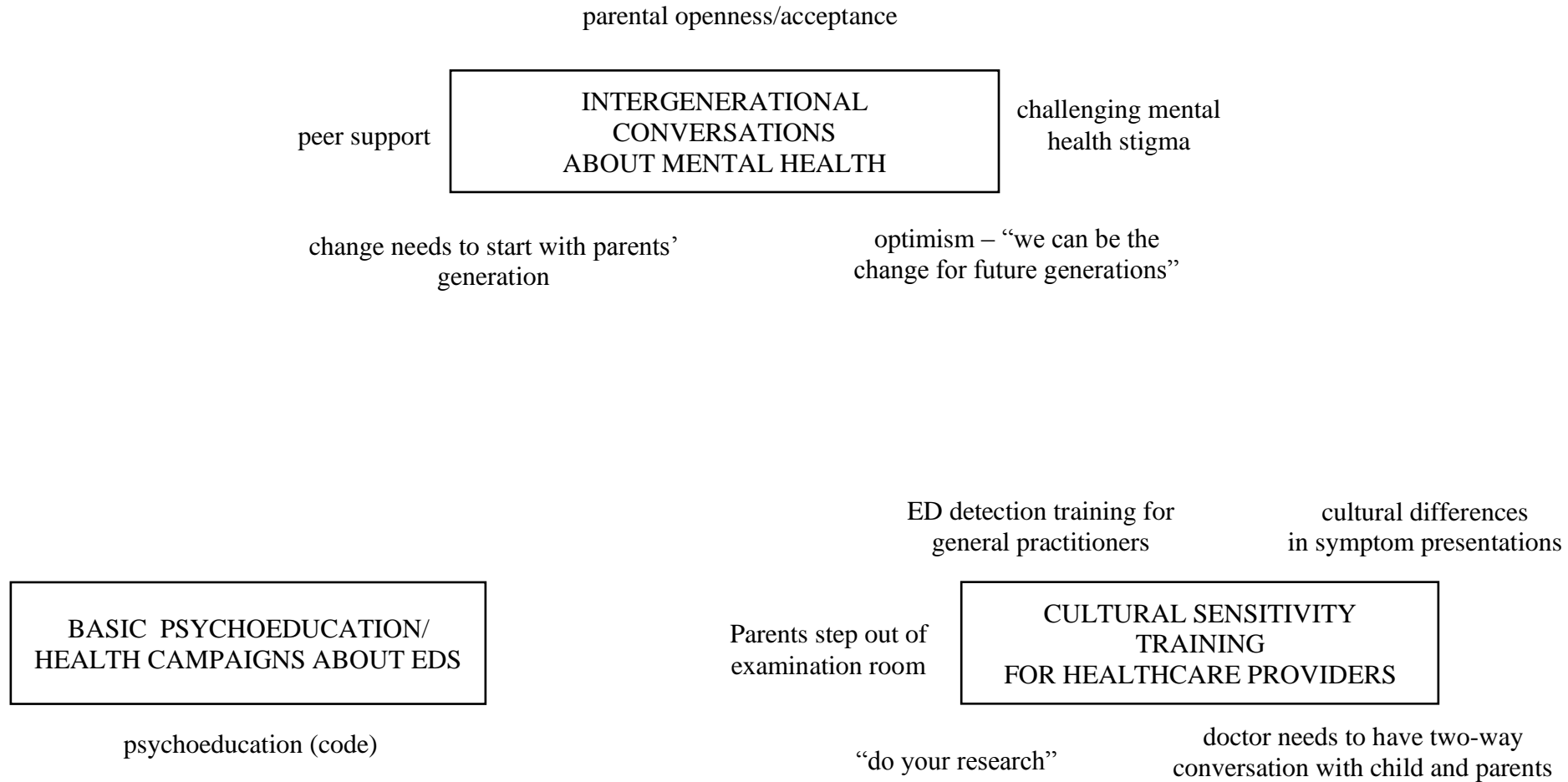


Figure 4. Thematic map for facilitators to eating disorders treatment uptake, displaying three major themes and their associated codes.  
Note. EDs = eating disorders.



## Appendix A

## Focus Group Recruitment Flyer

**SOUTH ASIA**

## Health, Wellness and Body Image among South Asian women

We want to work with you to learn more about body image, eating and wellness among South Asian women.

Our goal is to make it easier for members of the South Asian community to receive care by educating healthcare providers on the community's needs.

Attend a 1.5 hour focus group and provide your opinions!

**Eligibility criteria:**

- South Asian: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka
- Woman
- 18 years or older
- Must have lived in the U.S. for at least 3 years
- Must not have children

*Compensation and SONA credits are available.*

**Interested? Contact us!**  
Neha Goel,  
VCU Dept. of Psychology  
[REDACTED]

*Note.* Contact information was redacted for online publication.

## Appendix B

### Focus Group Interview Guide

1. What is your favorite homecooked meal? Who prepared it?
  - a. Probe: What do you think food says about your background/culture?
2. How were topics like physical appearance and body image discussed in your household or community, if at all?
3. What does the ideal South Asian woman look like?
  - a. Probes: What are the most important attributes/qualities about a South Asian woman that make her attractive?
  - b. Are there any other aspects of physical appearance that are important to this ideal?
  - c. Who comes to mind when you think of the “ideal” South Asian women?
  - d. Characteristics: age, self-presentation, physical appearance, physical appearance, body image, skin color, hair color, height, eye color, specific facial features, body parts
4. How are White American beauty standards and South Asian cultural beauty standards similar? How are they different?
  - a. Probe: What are the major challenges and pressures that South Asian women experience when trying to reconcile both beauty standards?
5. Do you think South Asian women experience family, cultural, or religious pressures to look and act a certain way?\*

6. Keeping this in mind, how does this stereotype affect the ways in which you and other South Asian women feel about their bodies and physical appearance (if at all)? How does it affect the way they might present themselves?\*\*\*
  - a. Probe: How do you think the model minority stereotype might affect the way they feel about their bodies?
7. Switching gears, how is mental health discussed within the South Asian community?
8. How are eating disorders talked about within the South Asian community, if at all?
  - a. Probes: How are eating disorders perceived within the South Asian community? Are they concealed?
9. Please describe any *physical characteristics* and *values* that you associate with a South Asian woman with an eating disorder.\*
  - a. Probe: Listen for any differences/similarities between descriptions of White and South Asian women.
10. What do you think are some of the barriers to eating disorders treatment for South Asian women?
  - a. Probe: Listen for family, structural, health barriers, lack of knowledge (e.g., do not perceive ED as problem)
11. What do you think are some things that health professionals can do to help more South Asian women seek treatment for an eating disorder?
12. What do you think is important for health professionals to know about preventing eating disorders within the South Asian community?
13. Were there any areas that I did not touch upon or something that you thought I would bring up but did not?

*Note.* EDs = eating disorders. \*After conducting the first three focus groups, the principal investigator and research faculty team member met to review the interview guide and decided to remove question 5 and replace question 9 with the following: “What is an “eating disorder”? What do your parents think is an eating disorder? What are the differences between your generation and your parents’ generation? \*\*For question 6, a uniform description of the model minority stereotype was provided to each focus group.

**Appendix C**

## Demographic Questionnaire

1. Age: \_\_\_\_\_
2. How did you hear about this study? \_\_\_\_\_
3. Year in school:
  - a. First-year (Freshman)
  - b. Sophomore
  - c. Junior
  - d. Senior
  - e. Fifth-year (Senior)
  - f. Graduate
4. What is the highest level of education completed by your mother (or primary female caregiver)?
  - a. Elementary school
  - b. High school
  - c. Bachelors
  - d. Masters
  - e. PhD
  - f. MD
  - g. JD
  - h. Other: \_\_\_\_\_
  - i. Not applicable (grew up in a single-parent household)
5. What is the highest level of education completed by your father (or primary male caregiver)?
  - a. Elementary school
  - b. High school
  - c. Bachelors
  - d. Masters
  - e. PhD
  - f. MD
  - g. JD
  - h. Other: \_\_\_\_\_
  - i. Not applicable (grew up in a single-parent household)
6. Which South Asian country does your mother (or primary female caregiver) descend from?
  - a. India
  - b. Bangladesh
  - c. Pakistan
  - d. Nepal

- e. Sri Lanka
  - f. Bhutan
  - g. Maldives
7. Which South Asian country does your father (or primary male caregiver) descend from?
- a. India
  - b. Bangladesh
  - c. Pakistan
  - d. Nepal
  - e. Sri Lanka
  - f. Bhutan
  - g. Maldives
8. Which South Asian country do your maternal grandparents descend from?
- a. India
  - b. Bangladesh
  - c. Pakistan
  - d. Nepal
  - e. Sri Lanka
  - f. Bhutan
  - g. Maldives
9. Which South Asian country do your paternal grandparents descend from?
- a. India
  - b. Bangladesh
  - c. Pakistan
  - d. Nepal
  - e. Sri Lanka
  - f. Bhutan
  - g. Maldives
10. Were you born in the United States?
- a. Yes
  - b. No
11. If you were not born in the United States, please list the number of years you have lived in the United States: \_\_\_\_\_ (in whole numbers)
12. What is your generational status in terms of your family's immigration pattern to the United States?
- a. You were born on the Indian subcontinent
  - b. **First-generation** (i.e., you were born in the United States, but at least one parent was born on the Indian subcontinent)
  - c. **Second-generation** (i.e., at least one parent was born in the United States)
  - d. **Third-generation** (i.e., at least one grandparent was born in the United States)
  - e. Other: \_\_\_\_\_

13. Please list the religion (if any) that was practiced your household growing up: \_\_\_\_\_

14. Please list your religious affiliation (if any): \_\_\_\_\_

15. Please list your current height (in inches): \_\_\_\_\_

16. Please list your current weight (in pounds): \_\_\_\_\_

17. Were there any areas that the group discussion did not address?

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### Author Vita

Neha J. Goel was born in St. Louis, Missouri in 1993 and is an American citizen. She graduated from Xavier College Preparatory in Phoenix, Arizona in 2011. She received her Bachelors of Arts in Psychology and American Studies from the University of California, Berkeley in Berkeley, California in 2015. She commenced her graduate studies at Virginia Commonwealth University in Richmond, Virginia in 2017. To request a copy of the author's curriculum vitae, please email her at [goelnj@mymail.vcu.edu](mailto:goelnj@mymail.vcu.edu).