

**The Lived Experience of South Asian Women Struggling With Disordered Eating:
Fostering a Culturally Sensitive Approach**

Mahnoor Chaudhry

Department of Counselling Psychology, City University of Seattle

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Hillary Sharpe, Ph.D., Registered Psychologist

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Abstract

This capstone project explores the unique challenges and experiences of South Asian women struggling with disordered eating, aiming to foster a culturally sensitive approach in mental health counselling. Utilizing a hermeneutic phenomenological method, this capstone provides an in-depth exploration of the complex interplay of cultural norms, societal pressures, environmental influences, and stigmas that exacerbate disordered eating behaviours in this population. This method was selected for its ability to deepen our understanding through interpretive engagement with lived experiences. This capstone examines a range of topics including but not limited to, gender roles, prevalent beauty standards, diet culture, media influences, the impact of racism, and acculturation. The literature reveals a significant gap in the existing mental healthcare system regarding the culturally specific needs of South Asian women, serving as a call to action for clinicians, researchers, and policymakers. By offering a deeper understanding of the complexities involved, this capstone aims to contribute to the development of therapeutic approaches that are both effective and culturally sensitive. This paper emphasizes the critical importance of cultural competence and outlines a roadmap for future research and practice, aimed at reducing healthcare disparities in treating disordered eating among vulnerable populations.

The Lived Experience of South Asian Women Struggling With Disordered Eating: Fostering a Culturally Sensitive Approach

Eating disorders are an essential and crucial area to study because they can severely impact an individual's physical and mental health, as well as their daily life and relationships (Rodgers & Melioli, 2016). They can lead to long-term health problems such as malnutrition, vitamin deficiency, refeeding syndrome, impaired cognitive functioning, cardiovascular disease, metabolic syndrome (i.e., heart disease and stroke), gastrointestinal disorders, reproductive health issues, and bone weakness (i.e., osteoporosis; Hambleton et al., 2022), and can also increase the risk of depression, anxiety, and other mental health issues (Rodgers & Melioli, 2016; Sander et al., 2021). Additionally, they can be challenging to treat and may require a multidisciplinary approach (Rome et al., 2003). Disordered eating usually occurs in females during adolescence or in their 20s (Aparicio-Martinez et al., 2019); however, it can occur at any age (Galmiche et al., 2019; Rohde et al., 2017).

Numerous risk factors are thought to interact to cause these disorders (Striegel-Moore & Cachelin, 2001). The etiology of eating disorders is multifactorial and involves a combination of genetic (i.e., vital heritability component), environmental (e.g., social media), psychological (e.g., a need for control), and cultural factors (i.e., cultural and societal expectations; Culbert et al., 2015; Rikani et al., 2013; Striegel-Moore & Bulik, 2007; Weissman, 2019). Some specific risk factors include a history of trauma, a poor body image, low self-esteem, and perfectionism (Culbert et al., 2015). Furthermore, Avena and Bocarsly (2012) found that changes in stress and food deprivation can also influence eating disorders in terms of brain chemistry, hormones, and neurotransmitters.

The National Initiative for Eating Disorders (NIED, 2020) reports that anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidance restrictive food intake disorder (AFRID), and other specified feeding and eating disorder (OSFED) are among the eating disorders that affect about 1 million Canadians. Since the COVID-19 pandemic, the overall rate of eating disorders is on the rise (Rodgers et al., 2020). It is crucial to recognize that research and literature on eating disorders have historically focused more on Caucasian females, leading to a lack of understanding and awareness of eating disorders in other cultural groups (Hesse-Biber et al., 2006; Pike & Dunne, 2015; Schaumberg et al., 2017). In recent years, there has been a growing recognition of the need to explore eating disorders within diverse cultural contexts (Mustafa et al., 2017). Researchers, clinicians, and advocacy organizations are increasingly working towards understanding how cultural factors intersect with eating disorders and influence diagnosis, treatment, and recovery (Halbeisen et al., 2022; Rodgers et al., 2018).

Between 2000 and 2018, the prevalence of eating disorders increased globally, rising from 3.5% to 7.8% (Galmiche et al., 2019). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychological Association [APA], 2013), the three most prevalent eating disorders are AN, BN, and BED (Silen & Keski-Rahkonen, 2022). AN is characterized by severe restriction of food intake and fear of gaining weight (APA, 2013; Peterson & Fuller, 2019). BN involves recurrent episodes of binge eating, followed by compensatory behaviours such as purging, fasting, or excessive exercise (APA, 2013; Mussell & Mitchell, 2001). Lastly, BED is characterized by recurrent episodes of binge eating without compensatory behaviours (APA, 2013; Bohon, 2019). The prevalence of eating disorders of the global population is estimated to be about 9% (Arcelus et al., 2011). The true prevalence, however, may be higher because many of these illnesses frequently go undiagnosed and

unreported (Smith et al., 2021). If untreated, eating disorders can have significant health repercussions for people of all ages, genders, sexual orientations, and ethnicities (Aparicio-Martinez et al., 2019; Pike & Dunne, 2015). In North America, researchers have increasingly acknowledged that individuals suffering from eating disorders require better access to resources and treatment (Rikani et al., 2013; Weissman, 2019).

In writing this literature review, I explored and identified the struggles of disordered eating for South Asian women, and the external and internal factors contributing to the lack of culturally sensitive approaches when receiving treatment. The literature review was conducted through a hermeneutic phenomenological lens, a philosophical approach that seeks to understand the meaning and interpretation of human experiences within a specific context (Thomas-Anttila & Solomon, 2023). A hermeneutic phenomenological approach is vital because it can highlight South Asian voices and experiences that have been overshadowed or not heard. Moreover, I believe there is a need to study the lived experience of South Asian women who lay on the spectrum of eating disorders to improve access to addressing health disparities and improving outcomes for this population. Thus, this paper symbolizes a call for a more culturally sensitive approach while learning, understanding, and improving the lived experiences of this ethnic minority population—a topic that is close to my heart.

Identifying as a South Asian female myself, I have succumbed to feeling the pressures to conform and live up to societal expectations. Women and girls of South Asian descent experience pressure to live up to an ideal body type and physical appearance rooted in societal and cultural ideas beginning at a young age (Awan et al., 2022). As a result, young girls frequently compare their bodies to unhealthy cultural images, feel pressure to conform to societal beauty standards, and consequent negative body image can trigger the development of an eating

disorder (Perloff, 2014). Mental health stigmatization as a barrier to eating disorder treatment-seeking for this group/population is one of the most common external factors (Goel et al., 2021; Javier & Belgrave, 2019). Additionally, in South Asian cultures, there is frequently a lack of knowledge and understanding concerning eating disorders, which can result in an incorrect diagnosis or a delay in treatment (Pike & Dunne, 2015).

The purpose of this capstone project is to address the current gap in the literature regarding South Asian women to answer the following three questions: what is the lived experience of South Asian women struggling with disordered eating; how can we make treatment more accessible to South Asian women and other ethnic/racial minorities who experience similar barriers; and how can we foster a culturally sensitive approach when working with ethnic/racial minorities?

Self-Positioning Statement

As a researcher who is a South Asian woman, I bring a unique perspective, cultural knowledge, and my own experiences to this literature review. However, my background and knowledge can impact this project in various ways. The first factor is my own bias and perspective; personal experiences, values, and beliefs on this topic may influence my interpretation of the data. As a researcher, I have endeavoured to be aware of my biases and reflect on how they may impact my interpretations. For example, mental health is highly stigmatized in my family. Nonetheless, that is why I have chosen this career to be able to break through these barriers not only for myself, but for those in my community.

As a woman from South Asia, I have a deeper understanding of the cultural context and attitudes towards eating disorders in my community, which can be an asset in fostering a culturally sensitive approach. Cultural sensitivity involves acknowledging and respecting

people's diverse cultures and backgrounds and adapting behaviours, actions, and communication to show understanding and respect for these cultural differences in various social and professional situations (Collins & Arthur, 2010; Goicoechea-Balbona, 1997). Given that I am of the same ethnic background, my experience is my own, and I can have varying values and perspectives on health care. Describing the cultural context on which the client bases their understanding of information is essential for managed care to succeed (Kalnins, 1997). This is an important consideration as cultural sensitivity includes the ability to understand, appreciate, and respect cultural differences that exist between people (Karasz et al., 2019; Sue et al., 2009). As I have undertaken this capstone project, I endeavoured to be aware of and sensitive to the unique customs, beliefs, values, and traditions of individuals and groups from similar cultural backgrounds.

I have navigated cultural expectations around body size, shape, and appearance. The pressure to conform to cultural norms around thinness or a preference for lighter skin tones can lead to body dissatisfaction and disordered eating behaviours (Aparicio-Martinez et al., 2019; Warren & Akoury, 2020). I have shared my intimate perspectives and understandings throughout this capstone project, which can add richness and depth to the findings. This is integral in hermeneutic phenomenology, which I will further explain in the methods section. Academic research and literature can be valuable tools for exploring help-seeking behaviours. However, most importantly, the exclusive experiences of individuals with the resiliency to share their lived experiences are critical to this literature review. I am deeply aware of the cultural nuances and complexities that can impact the experiences and perspectives of women from South Asia. Being a South Asian woman has given me valuable insights that have formed my capstone approach and commitment to promoting inclusivity in all aspects of my work. I have tried to be mindful of

the potential biases and assumptions that can influence capstone findings and to approach the literature with an open and empathetic mind. I am dedicated to amplifying the voices of this marginalized community and advocating for more accurate representation and equity in all areas of research.

Moreover, recognizing my researcher positionality for this capstone project has been essential for conducting ethical and culturally responsive research. Furthermore, it has allowed me to increase accountability, credibility, and transparency. Throughout the research and writing process I have utilized a hermeneutic phenomenological field journal to keep my potential biases and preconceptions forefront of my awareness. Ultimately, the beauty of this capstone project is the essence of the different and unique lived experiences of women and girls from South Asia and their experiences with disordered eating and eating disorders.

Ethical Considerations

Ethical considerations should be examined particularly when researching individuals or communities from vulnerable backgrounds. As outlined in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017), adhering to the four principles is essential to maximize the benefit and minimize harm to individuals. It is crucial that I abide by the *Standards of Practice* (College of Alberta Psychologists, 2019) and that my literature review does not perpetuate harmful stereotypes or contribute to the stigmatization or marginalization of these populations. This has involved being mindful of the language and terminology used in the capstone project and actively challenging any biases or prejudices that arise. Additionally, it is essential to consider the cultural norms and practices of the population being studied. This involved adapting my research methods and procedures to be more culturally appropriate. Hence,

a hermeneutic phenomenological approach was utilized to remain mindful of potential cultural sensitivities.

Several research articles identified three ethical justices to guide priority decisions in accessing treatment (Frostad & Bentz, 2022; Richards et al., 2022; Scheunemann & White, 2011). The first is egalitarianism, which aims to reduce disparities and promote equality in lifelong health (Richards et al., 2022). It is related to the notion of “first-come, first-served” or lottery distribution and is founded on the idea that everyone equally deserves a healthy life (Richards et al., 2022; Whitehead, 1994). The second is utilitarianism, which focuses on treating those who will benefit the most and seeks to maximize the population’s overall benefit (Cookson & Dolan, 2000; Persad et al., 2009; Richards et al., 2022). Lastly, prioritarianism triages those who are the worst off or in need of care (Persad et al., 2009; Richards et al., 2022).

It has become an increasing ethical issue that the priority of patients for eating disorder services is often determined by first-come, first-served, their medical risk and severity, followed by the order in which they are referred (Kuek et al., 2023; Richards et al., 2022). This highlights an issue around treatment where South Asian women experience greater barriers to treatment (e.g., stigma), so there is an ethical imperative to address these barriers if these are considered fair. Subsequently, another social justice issue is that if an individual is lower on the spectrum of disordered eating behaviours, they may need to wait until they have a clinical diagnosis to access treatment or must remain on a waitlist until their symptoms worsen (Frostad & Bentz, 2022; Richards et al., 2022). This process raises moral challenges as it requires weighing institutional requirements, professional concerns, and moral and ethical standards, making prioritization decisions quite complex (Varkey, 2021). Furthermore, this raises questions about fairness and

access to treatment, as well as the responsibility of healthcare providers to provide appropriate treatment.

Various ethical principles arise, including autonomy as outlined in the Canadian Counselling and Psychotherapy Association (2020), which emphasizes an individual's right to make decisions about their health and well-being. By delaying access to treatment for individuals who do not meet diagnostic criteria for an eating disorder, their autonomy may be compromised as they cannot make informed decisions about their health. Clausen et al. (2013) suggested that pre-treatment autonomous motivation to change is linked to better results for dietary restrictions, binge eating, and cognitive and affective eating behaviours. Hence, maintaining a client's freedom and independence may enhance their healing journey (Bohon, 2019; Bohon & McCurdy, 2014).

Method

I have drawn on the works of philosophers such as Martin Heidegger and Hans-Georg Gadamer to offer valuable insights into the hermeneutic phenomenological approach to understanding the experiences of women from South Asian backgrounds struggling with disordered eating. Both philosophers offer a unique perspective on the role of culture, language, and interpretation in shaping our understanding (e.g., Gadamer, 1989; Heidegger, 1962; Regan, 2012), and this can be particularly helpful when exploring eating disorders. Heidegger's emphasis on cultural background and historical context is beneficial in understanding how cultural and societal pressures shape individuals' experiences of body image and disordered eating (Horrigan-Kelly et al., 2016). This means recognizing how cultural and societal pressures to conform to specific beauty standards and family values may influence individual experiences (Nazir, 2015).

Gadamer's (1989) focus on dialogue and understanding provides a lens through which we can explore how we might foster open communication and collaboration between clients, families, and mental health providers in the treatment process (Horrigan-Kelly et al., 2016). Gadamer's approach also emphasizes the importance of recognizing how cultural and societal factors shape our understanding of phenomena and offers a lens through which we can make meaning (Walsh, 2003). Thus, I believe that this means acknowledging the influence of cultural values and beliefs on the perceptions of body image and disordered eating and recognizing the social and familial pressures that may influence help-seeking behaviours.

This process revealed several subthemes from my interaction with the literature. From these subthemes, I have developed implications for counselling, fundamental next steps for research, and recommendations for practice, which will be presented in the second half of this paper.

Literature Review

Disordered eating and eating disorders are related, but distinct concepts on a spectrum of disordered eating behaviours (Hawkins-Elder & Ward, 2020). At one end of the spectrum, some individuals have a healthy relationship with food and eating. In contrast, on the other end of the spectrum, there are individuals with diagnosed eating disorders (Eikey, 2021). In between these two, some individuals exhibit various levels of disordered eating behaviours, which range from occasional dieting or overeating to more severe and persistent patterns of disordered eating, often accompanied by feeling guilt around eating certain foods (Eikey, 2021; Hawkins-Elder & Ward, 2020).

The term *disordered eating* refers to a variety of problematic eating behaviours that do not meet the criteria for a clinical eating disorder, however, can still have adverse effects on an

individual's physical and mental health (Aparicio-Martinez et al., 2019; Coelho et al., 2014). Examples of disordered eating behaviours include skipping meals, rigidly following diets, using laxatives or diuretics to manipulate weight, obsessively counting calories or macronutrients, and engaging in fasting or purging behaviours (Eikey, 2021; Neumark-Sztainer et al., 2011; Reiter & Graves, 2010). Disordered eating behaviours can be warning signs or risk factors for developing an eating disorder (Culbert et al., 2015). Individuals may be more likely to develop AN or BN if they frequently participate in strict dieting or excessive exercise (Hay et al., 2015; Mussell & Mitchell, 2001). Similarly, an individual who frequently binge eats may be at increased risk for developing BED (Field et al., 2008; McCuen-Wurst et al., 2018). While disordered eating behaviours do not necessarily indicate the presence of an eating disorder, they may escalate into an eating disorder (Aparicio-Martinez et al., 2019).

Eating disorders can be caused by a complex interplay of biological, genetic, environmental, and psychological factors (Culbert et al., 2015; Rohde et al., 2017). Most often, individuals with these issues are consumed with thoughts of food, weight, and body image (Aparicio-Martinez et al., 2019; Rodgers & Melioli, 2016). It is a group of mental illnesses characterized by persistent disturbances in eating behaviour, thoughts, and emotions (Rikani et al., 2013). They are often accompanied by intense shame and guilt and are challenging to treat without professional help (Corno et al., 2022; Granieri & Schimmenti, 2014).

Eating disorders have historically been thought to affect only white women (Gordon et al., 2002; Sala et al., 2013). Several researchers have shown that specific diverse populations and men have lower rates of diagnosed eating disorders (Becker et al., 2003; Cachelin et al., 2001; Marques et al., 2011; Richardson & Paslakis, 2021; Sala et al., 2013). There may be several factors as to this, including variations in the clinical presentation that traditional instruments that

were created primarily for white populations cannot capture (Sala et al., 2013), differences in treatment rates as a result of help-seeking behaviour (Becker et al., 2003), and both the individual and clinician not being aware of the eating disorder (Cachelin et al., 2001). Hence, it has been postulated that these populations are similarly affected by eating disorders, but poorer diagnosis and treatment rates could be attributed to a clinician error or bias in diagnosing and referring to eating disorders (Becker et al., 2003; Sala et al., 2013).

This literature review identifies the lived experiences of South Asian women struggling with disordered eating. For further clarification, South Asian countries are comprised of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka (Ranjan & Asthana, 2017). The literature reveals that there are 150–200 million people in the South Asian region with psychiatric illnesses (Ranjan & Asthana, 2017; Trivedi et al., 2007; Trivedi et al., 2010). Specifically, women of these populations experience substantial obstacles to accessing treatment, including shame, silence, and social stigma about mental health, parents' mental health fears, lack of knowledge and resources regarding eating disorders, and the biases of healthcare professionals (Channa et al., 2019; Goel, 2019; Goel et al., 2022). However, in reality, the rate of eating disorders in women of South Asian descent is increasing by the day (Wu et al., 2020) for reasons that I will explain and support more fully in the sections to follow.

In the following literature review, I explored two concepts: 1) research on girls and women struggling with disordered eating and 2) the lived experiences of girls and women of South Asian background struggling with disordered eating. Thus, I have organized the literature review into three subheadings consisting of cultural, social, and environmental influences. The nine subthemes chosen for each subheading can be applied to different subheadings, and though I acknowledge that there are several overlaps, this is how I see the subthemes fit. Moreover, I

have incorporated an amalgamation of personal reflections by friends, family, and myself to highlight the essence of these themes.

Cultural Influences

Gender Roles and Marriage

In many South Asian cultures, traditional gender roles and societal expectations significantly emphasize marriage, family, and domestic responsibilities (Bhatti, 2018; Iyer & Haslam, 2003; Karasz et al., 2019). Research has suggested that women may be reluctant to seek treatment for eating disorders because they frequently feel pressured to put the interests of their families before their own (Anand & Cochrane, 2005; Iyer & Haslam, 2003). Kramer et al. (2002) and Karasz et al. (2019) found that seeking help for these issues may be seen as a sign of weakness, leading to a hesitancy to seek treatment for women of colour. Societal and cultural norms in South Asian communities have often encouraged the suppression or elimination of difficult emotions to maintain social harmony and respect societal expectations (Murata et al., 2013; Nagayama et al., 2011; Pernau, 2021). However, it is critical to avoid overgeneralizing this practice to all South Asians as such tendencies are not exclusive to South Asia and similar patterns can be seen in various cultures worldwide (Sun & Lau, 2018). Nonetheless, this stigma may be further compounded by the pressure to conform to societal beauty standards, which can be especially strong for South Asian women as means to feel accepted by the community (Bhatti, 2018; Goel et al., 2021; Karasz et al., 2019).

Marriage is a crucial life milestone in many South Asian cultures (Malla et al., 2022). The pressure to find a suitable partner and start a family can be overwhelming, leading to anxiety and stress, which may trigger or worsen eating disorders (Mustafa et al., 2017; Mustafa et al., 2018). Additionally, women may feel pressured to conform to traditional beauty standards, such

as having fair skin, slim bodies, and long hair, further exacerbating body image issues and disordered eating behaviours (Bhatti, 2018; Shankar & Subish, 2007). Moreover, South Asian cultures are often collectivistic, meaning that individuals are expected to prioritize the needs and desires of the family and community over their personal needs (Karsaz et al., 2019). As a result, it can create a sense of guilt or shame for seeking help for an eating disorder, as the individual may feel that they are betraying their family or community by prioritizing their health (Bhatti, 2018; Kramer et al., 2002; Mustafa et al., 2017). Goel et al.'s (2021) study examined women from South Asia's conceptualization of eating disorders and body dissatisfaction. One of their participants explained the pressure to conform to specific standards of appearance:

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." (Goel et al., 2021, p. 2517)

The statement describes the way that gender roles significantly influence women from this population who struggle with disordered eating. Grewal et al. (2005) and Sharma et al. (2016) found that in many traditional South Asian families, women are expected to be caretakers and homemakers, responsible for cooking, cleaning, and caring for children and elderly relatives. As a result, it can make it difficult for these women to prioritize their health and well-being, as they may feel guilty for taking time away from these responsibilities (Karsaz et al., 2019; Kramer et al., 2002).

Furthermore, cultural values around modesty and privacy can make it difficult for this population to openly discuss their struggles with eating disorders (Goel, 2019; Mustafa et al., 2018). Discussing these issues with family members or healthcare professionals may be deemed inappropriate, leading to a lack of support and understanding from family members (Karsaz et

al., 2019). Kramer et al. (2002) suggested that there are stigmas and obstacles to receiving mental health care in many communities and cultures worldwide. As a result, it is crucial to address the unique difficulties experienced by South Asian women, but it is equally important to recognize the broader societal and systemic factors that contribute to these issues (Eylem et al., 2020; Turan et al., 2019; Zhang et al., 2019).

Beauty Standards, Body Dissatisfaction, and “Ideal” Body Image

The beauty standards deeply rooted in historical and sociocultural contexts prevalent in South Asian cultures place a high value on characteristics such as thinness and fair skin. Many of these ideals trace back to colonial times when fair skin was considered a symbol of higher social status and power associated with European colonizers (Shankar & Subish, 2007). In contrast, darker skin was associated with lower working classes, typically involved in outdoor labour (Shankar & Subish, 2007). Goel et al.’s (2021) study examined South Asian women's conceptualization of eating disorders and body dissatisfaction, and revealed the following from a participant: *“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”* (p. 2516).

The construct of “fairness” and the pressure to conform/strive towards this constructed beauty ideal reinforces the notion that women from South Asia can and should change their appearance and that their worth is tied in closely with their bodily appearance, a harmful idea that can promote the development of eating disorders (Javier & Belgrave, 2019).

Additionally, modern media and advertising platforms, expanded on below, contribute significantly to the perpetuation of these beauty standards, often projecting thin, fair-skinned models and celebrities as embodiments of ideal beauty (Javier & Belgrave, 2019). Modern

media's promotion of thin, fair-skinned ideals among South Asian women can be traced back to colonial influences that associated whiteness with beauty and power (Sahay & Piran, 1997). This media perpetuation amplifies existing cultural pressures, making South Asian women more susceptible to body dissatisfaction and eating disorders (Majidi, 2020). Such widespread distribution of narrow beauty ideals applies considerable pressure on South Asian women, potentially leading to body dissatisfaction and contributing to the development and rise of eating disorders (Bhatti, 2018; Frederick et al., 2022). Thus, the colonial legacy adds a complex layer to the impact of contemporary media on beauty standards within this community and understanding the colonial context is crucial for developing targeted interventions and policies that address the root causes of body dissatisfaction and eating disorders among South Asian women.

The societal and familial pressures that tie women's worth to their physical appearance can exacerbate these issues, creating a dangerous cycle of negative self-perception and disordered eating behaviours. Moreover, the focus on comparing beauty standards may ignore other critical elements that contribute to body dissatisfaction, such as discrimination and objectification based on appearance (Cheng & Youngju Kim, 2018; Frederick et al., 2022). An example of this can be found in Wales et al.'s (2017) study, where a participant revealed that in South Asian cultures, as individuals approach marriageable age, there is an overt focus on maintaining a certain weight for better marital prospects; the participant revealed the following:

Culturally it's kind of when the girl gets to a certain age, or a boy gets to a certain age it's about getting married, so you need to be a certain weight, or you won't find a partner. And I think sometimes parents do put that into children's heads. Like 'oh don't overeat now, you need to start losing weight now' so they talk about weight a lot. (p. 44)

Adding another layer of complexity to these issues is the cultural shift observed in South Asian societies from favouring fuller-bodied women (symbolizing wealth and reproductive health) to valuing thinness, seen as a symbol of self-control and adherence to colonial concepts of beauty and health (Bush et al., 2001; Karasz et al., 2019; Majidi, 2020). The continuous comparison with these narrowly defined beauty ideals can lead South Asian women towards feelings of inadequacy and an urge to modify their appearance to be perceived as attractive (Bhatti, 2018; Iyer & Haslam, 2003). When comparisons result in perceived failure to meet these ideals, they can have profoundly detrimental effects, such as low self-esteem and even self-hatred (Javier & Belgrave, 2019). However, acknowledging that beauty standards are culturally specific and subjective can be a crucial first step toward mitigating these issues. There is an urgent need to promote a broader, more inclusive definition of beauty that counters the negative consequences of comparison and fosters positive body image (Paraskeva et al., 2017).

Unfortunately, the prevailing beauty standards and associated body dissatisfaction often form significant barriers preventing girls and women of South Asian backgrounds from seeking help for their eating disorders (Paraskeva et al., 2017). The cultural stigma around mental health and the lack of culturally relevant treatment options further contribute to this problem (Karasz et al., 2019). Addressing these challenges calls for a comprehensive, culturally sensitive approach that includes education about media literacy, fostering self-esteem and resilience, promoting acceptance of body diversity, and challenging the prevalent harmful beauty norms. Furthermore, interventions need to focus on these aspects, along with efforts to reduce the stigma around mental health and enhance the availability of culturally appropriate treatments, which I will expand on in the following sections.

Customary Relationship With Food and Health

South Asian cultures often have strict gender norms around eating, food, and health (Chapman et al., 2011; Holmboe-Ottesen & Wandel, 2012; Patel et al., 2012). Women are expected to eat smaller portions and avoid certain foods to remain thin, whereas men are encouraged to eat more to “preserve strength” (Bhatti, 2018; Chowbey, 2017). Consequently, this can lead to shame and embarrassment for women who struggle with disordered eating behaviours and may further prevent them from seeking treatment (Chapman et al., 2011; Choudhry, 1998).

Goel et al. (2021) conducted a qualitative study to examine this population’s conceptualization of eating disorders and body dissatisfaction. They found that within this cultural context, food is often associated with hospitality, love, and generosity. However, this cultural value also presents a paradox. On one hand, refusing food might be deemed as disrespectful, putting those with eating disorders in a difficult position. On the other hand, societal messages demand moderation in eating and maintaining thinness, often associated with desirability or being “marriage material.” This contradicting scenario might cause individuals with eating disorders to hesitate in rejecting food, feel guilty when doing so, and result in disordered eating behaviours such as restricting, purging, and bingeing. Therefore, they are forced to navigate this impossible tight rope, balancing cultural expectations and their struggles with food and body image (Bhatti, 2018; Goel et al., 2021; Mustafa et al., 2017).

In South Asian cultures, meals are frequently central to social events and family gatherings (Gadgil et al., 2020). There is also a pressure to eat and enjoy food as a way of showing appreciation and eating large portions of food is frequently considered a gesture of hospitality and respect (Chapman et al., 2011). However, this cultural emphasis on food and

eating can also contribute to the development of eating disorders, particularly if an individual feels that they cannot control their food intake or that they must restrict their food intake to meet cultural standards of beauty or health (Choudhry, 1998; Mustafa et al., 2017; Mustafa et al., 2018). South Asian cultures strongly emphasize maintaining good health, and individuals may be encouraged to eat certain foods or follow specific diets to promote their health (Chapman et al., 2011; Choudhry, 1998).

Consequently, this emphasis on health can sometimes lead to disordered eating behaviours, as individuals may feel pressure to meet specific health standards or become overly focused on their physical appearance (Bhatti, 2018; Goel et al., 2021). South Asian cuisine often includes dishes that are rich in flavour and use ingredients such as ghee (clarified butter), oil, and sugar which can contribute to a higher risk of obesity and related health problems such as type 2 diabetes, heart disease, and hypertension (Salis et al., 2021). As a result, girls and women from South Asian backgrounds may face cultural pressures to maintain certain standards of what is deemed healthy, which can lead to disordered eating behaviours, such as restrictive eating or bingeing and purging (Choudhry, 1998).

Anand and Cochrane's (2005) meta-analysis found that cultural perceptions, along with a lack of awareness, and the stigmatization of mental health problems, often result in symptoms of eating disorders being attributed to physical health issues, which consequently may delay proper diagnosis and treatment, leading to potential worsening of the condition. Wales et al. (2017) explored barriers to South Asians' help-seeking for eating disorders and revealed the following from a participant:

I don't think in the South Asian community we think of eating disorders. If we see someone losing weight or gaining weight, they think to the more traditional diseases and they tell you something like you might have thyroid problem. (p. 45)

Similarly, Goel et al. (2021) also found that due to the lack of knowledge, South Asians may struggle to distinguish between a health problem and mental health issue. Furthermore, Anand and Cochrane (2005) and Karasz et al. (2019) suggested that the lack of knowledge and understanding of eating disorders and mental health among South Asian communities and healthcare professionals can further exacerbate the health risks associated with disordered eating.

Field Journal #1

As I dived into my capstone project, I felt consumed by my experiences and relationship with food. I have struggled for a significant part of my adolescent years to maintain a healthy relationship with food. I come from a Pakistani background, and as found in the literature, food is central to anything and everything we do in my household. My grandma always ensured I was full of food and love; it was her mantra. I found myself in a difficult position to not be disrespectful towards her if I refused to eat three plates full of food, and my agenda was to restrict my food intake to remain thin. Similarly, I had asked a family member about their experience of disordered eating and cultural influences; they stated, *“it's a brown household, things like this just don't exist for us and if we talk about it, we are acting disrespectful and rude.”* While I do not consider myself to have an eating disorder, I believe that I have engaged in disordered eating behaviours. I have felt dissatisfied with my body and have compared my self-worth to my physical appearance. This was especially relevant as I was growing up, and marriage was fundamental to many conversations with family members. I was always told that I needed to look a certain way externally to find a partner. However, no one ever asked how I felt

internally and what it meant to me. I had developed a narrative that a partner would not care about what was on the inside and would only judge me for what I was on the outside. This was a narrative that I have had to combat from a young age, and I have found peace in my adult years that knowing that my physical appearance is not the only commodity I have to offer.

Social Influences

Influence of Media

South Asian females' willingness to access treatment for eating disorders can be strongly influenced by media and peer pressure (Pike & Dunne, 2015). Social media platforms encourage unrealistic beauty standards that can be challenging due to cultural disparities in body type and size (Reddy & Crowther, 2007). According to Goel et al. (2021), sociocultural theories regarding eating disorders suggest that cultural, environmental, and societal ideas are endorsed through sources such as family, peers, and media, which impact the conceptualization of eating behaviours and body image (Khasru, 2022).

Additionally, social media has become a significant source of misinformation regarding beauty standards in today's world. Unfortunately, the standards that social media promotes are often narrow, limited, and false (Paraskeva et al., 2017). Social media platforms such as Instagram and Facebook consist of various constructed and idealized images often impacting women's body dissatisfaction (Tiggemann & Anderberg, 2020). Moreover, this can be incredibly challenging as women may feel pressure to conform to beauty standards that do not align with their cultural traditions leading to disordered eating behaviours (Reddy & Crowther, 2007). Goel et al. (2021) asked a participant to identify both American and South Asian media influences, which revealed:

I feel like it's [media in non-Western countries] really heavily based on Western influences and like styles and fashion and like body images, beauty standards, etcetera. So, I have a cousin and she's lived in India all her life . . . And so I know she tells us to send [her] things that are . . . like fashion . . . from America . . . and I think that's where . . . 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 I feel like that's like kind of contradictory. (p. 2519)

Through an increasing overrepresentation of artificially perfected images that do not represent much of the general population, the mass media have shaped and reinforced the current cultural appearance ideals, which emphasize thinness for women (Sypeck et al., 2004). Idealized media photos are frequently altered by computers using techniques like airbrushing with slimmer thighs and toned muscles (Paraskeva et al., 2017). The edited images create an aesthetically pleasing photo that is often unattainable in biological reality (Paraskeva et al., 2017). Meta-analyses of experimental and correlation studies by Barlett et al. (2008) and Grabe et al. (2008) established the connection between exposure to these manipulated media representations and poor body image, a potential risk factor for developing eating disorders.

There remains a debate in the literature on whether internalizing a thin ideal body standard results in low body self-esteem and dysregulated eating behaviours. Many studies have demonstrated how thin women in the media affect female viewers' self-esteem in detrimental ways (e.g., Hawkins et al., 2004; McComb & Mills, 2020; Paraskeva et al., 2017; Perloff, 2014; Pike & Dunne, 2015; Wilcox & Laird, 2000). However, other studies have pointed to a more complex interplay; for example, a multivariate analysis conducted by Reddy and Crowther (2007) found that internalizing the thin beauty ideal was not significantly correlated with body

self-esteem or eating behaviours. Instead, the researchers found that cultural conflict with the Western ideal was correlated with low body self-esteem and disordered eating, which I will further explain in the last theme of the literature review.

Diet Culture

Chapman et al. (2011) looked at South Asian Canadians' perspectives on the meanings of food and well-being. The study found that many individuals stated that a "healthy" diet should follow the standards of Canada's Food Guide and that the South Asian diet lacks nutritional requirements due to the foods consumed in South Asian cuisines. The South Asian diet was characterized as being high in carbohydrates and fats, while a Canadian diet was characterized as having a balance of proteins, fats, carbohydrates, fruits, and vegetables (Chapman et al., 2011; Choudhry, 1998).

As Chapman et al. (2011) and Choudhry (1998) described, South Asian cuisine consists of starchy foods as typical dishes consisting of rice, naan, or roti (flat bread), with curries that are cooked with meats, lentils, or vegetables cooked in ghee (clarified butter), oil, and occasionally high-fat creams or milk. South Asian food is perceived as being less healthy than Canadian cuisine because it uses more fats and carbohydrates with less protein and vegetables (Bhatti, 2018; Chapman et al., 2011). As a result, Palaniappan et al. (2018) explained that individuals from this population are more likely to experience numerous health problems and chronic diseases such as heart disease and type-2 diabetes. Individuals of South Asian backgrounds have become increasingly aware of the health dangers and may strive to control their diets by having fewer fats in their meals to prevent health problems (Holmboe-Ottesen & Wandel, 2012).

Goel et al. (2021) examined women of South Asian background's conceptualization of eating disorders and body dissatisfaction. A participant was asked to share her experience of appearance stigma from family members and revealed the following:

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 like, 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." (Goel et al., 2021, p. 2517)

Furthermore, women of this population are applauded when they diet or restrict their food intake (Goel et al., 2021; Holmboe-Ottesen & Wandel, 2012). On the other hand, when a woman overeats, they may be subjected to ridicule and can be deemed fat (Goel et al., 2021). Thus, South Asians who struggle with insecurities regarding their body and weight often adopt eating behaviours that align with Western perspectives of food and nutrition to reduce shameful and discouraging comments from family members (Chapman et al., 2011; Choudhry, 1998).

Field Journal #2

As I reflect on this section, I feel captivated by the experiences recounted in the literature of these brave women who have shared their stories. The beauty of hermeneutic phenomenology surrounding eating disorders and South Asian experiences allowed me to feel understood yet, sad. I have felt the pressure to conform to societal beauty standards for many years. Given the lack of South Asian representation in the media, I tried to fit in with what felt like the acceptable standard of white beauty. Even when I saw a person of colour in a TV show, they were always portrayed as the bigger, nerdy friend, never the thin, pretty, and intelligent protagonist. I remember thinking, "well thank god I do not look like that, I am thinner than her." Looking back, I further reinforced the narrative of wanting to assimilate into Westernized beauty ideals. I

had become the antagonist in my own story and felt no self-compassion towards myself. Consequently, I felt like the odd one out at school when I would bring chicken curry and rice to school, whereas my peers would bring a turkey sandwich with fruits and vegetables on the side. It almost felt like an embarrassment to share my cuisine with the outside world because my diet differed from theirs. As stated by a family member, “I felt for the longest time that if I continued to eat Desi [South Asian cuisine] food, I would keep getting fat and when I told my mom I only want a salad, I got yelled at.” Conversations like these felt highly relatable to me as I have also felt victim to this. I felt insecure in my body and became fixated on looking at a scale. It felt like my happiness was associated with a number. However, as I got older, I realized that my body deserves the same love I give to those around me who have had similar experiences.

Environmental Influences

Acculturation and Conflicting Worldviews

As South Asian women migrate to Western countries and become more acculturated to Western norms and values, they may be exposed to new and different standards of beauty that prioritize thinness or muscularity (Iyer & Haslam, 2003). Bhatti (2018) defined *acculturation* as “the processes through which non-Western individuals absorb the norms and traditions of Western culture, which include adopting the thin body image ideals of Western culture” (p. 20). Several studies suggest that girls and women of South Asian descent are more likely than white women to engage in disordered eating behaviours due to acculturation to Westernized notions of body appearance (Furnham & Adam-Saib, 2001; Iyer & Haslam, 2003; Khusra, 2022; Mumford et al., 1991; Reddy & Crowther, 2007). Goel et al. (2021) asked a participant to identify the challenges in navigating both South Asian and Western cultures, she stated:

[W]e kind of live in a dual culture thing and we try to find our balance . . . it was me dealing with a bunch of American culture [in school], 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. (p. 2521)

Furnham and Adam-Saib (2001) and Mumford et al. (1991) found that culturally specific characteristics drive South Asian females to engage in disordered eating behaviours, as there are more reports of South Asian women engaging in unhealthy eating behaviours than non-South Asian women. Furthermore, Reddy and Crowther (2007) suggested that young South Asian women in North America face more significant pressure to fit in with their white peers, such as having a lighter skin complexion and a slimmer body type. One study found that many women from South Asia changed their bodies to some extent to look less South Asian (George & Rail, 2005). Consequently, these women had undergone cosmetic surgeries such as skin bleaching, which were considered necessary and normal (George & Rail, 2005).

The Impact of Racism

The role of racism rooted in colonialism in shaping the experiences of South Asian women and their body image should not be underestimated. Iyer and Haslam (2003) proposed that negative comments on one's ethnic appearance are associated with a higher risk of eating disorders. These derogatory remarks emphasize ethnic disparities, reduce women's self-confidence, and heighten their desire to modify their physical appearance (Iyer & Haslam, 2003). As a result, women alter characteristics within their control, such as body shape and weight, to bolster their self-esteem and to fit in with their white peers by adopting a Western appearance

(George & Rail, 2005; Iyer & Haslam, 2003). This racist experience directly contributes to the increased risk of disordered eating behaviours among South Asian women, signifying the profound impact of racism on mental health.

Racism, whether overt or subtle, often results in psychological stress, which is known to impact mental health disorders such as eating disorders (Cheng et al., 2017). Bodell et al. (2018) highlighted the multilayered relationship between race and the pathology of eating disorders, implying that race could be a determining factor in unique patterns of symptom development. This includes the importance of tailoring prevention programs to acknowledge and address racial differences in both the emergence and manifestation of symptoms (Bodell et al., 2018). Moreover, Watson et al. (2013) emphasized the harmful effects diverse women face when they adopt the thin-ideal beauty standard. The association with predominant Western beauty standards not only leads to heightened body awareness, but also triggers feelings of body shame, anxiety regarding appearance, and tendencies toward disordered eating (Watson et al., 2013).

Simone et al. (2022) suggested the importance of taking ethnic, racial, and gender identities into consideration when examining the prevalence of health risk behaviours. The researchers found that eating disorder behaviours from adolescence to adulthood can differ based on factors such as experiences of marginalization and discrimination, social position, and challenges to body perception by individuals who belong to socially marginalized ethnic/racial and gender groups (Simone et al., 2022).

These studies highlight the importance of considering race-related stressors when addressing eating disorder risks in diverse populations and confirm the need for more comprehensive, culturally sensitive, and racially inclusive research on the link between racism

and eating disorders. Thus, it is crucial to develop interventions that address the harmful effects of racism while simultaneously promoting positive ethnic-racial identities.

Collectivist vs. Individualist Ideologies

As mentioned previously, cultural conflict can occur when an individual or group experiences a clash between their cultural beliefs, values, and practices and those of the dominant culture around them. They can result in intergenerational conflicts within families, as different generations may hold different beliefs and values based on their experiences and cultural backgrounds. As Reddy and Crowther (2007) wrote:

cultural conflict can be defined as the negative affect and cognitive dissonance resulting from an attempt to assimilate values and expectations of the majority culture and one's own culture... These conflicts have the potential to create psychological and emotional distress as well as familial conflict. (p. 46)

Khasru (2022) defined *cultural conflict* as “the tension between two diverse cultures- in this case, the tension between individualist, dominant American culture, versus the collectivist culture of South Asia” (p. 55). Individualist cultures typically emphasize personal autonomy, self-expression, and individual achievement, while collectivist cultures prioritize social harmony, group cohesion, and interdependence (Bond, 2004). Thus, when a South Asian woman is placed into a position of conflicting ideologies, it could make them less likely to seek treatment for fear of disrupting the group dynamic or bringing shame to their family or community (Pike & Dunne, 2015).

Most South Asians are Muslim, Hindu, or Sikh (Bonfanti, 2015), thus, religious and cultural expectations can place limitations on a women's independence and self-expression, such as promoting the idea of dressing modestly, refraining from explicit clothing, and prohibiting

premarital relationships (Bonfanti, 2015; Mustafa et al., 2017). Thus, from an early age, girls and women of South Asian backgrounds raised in Western society are taught to set themselves apart from their Western counterparts (Mustafa et al., 2017). As these populations begin to internalize the conflicting worldviews of adapting to the dominant Western culture and maintaining traditional South Asian values, it can lead to an increased need for bodily control, thus triggering maladaptive eating behaviours (Mustafa et al., 2017; Nazir, 2015).

Internal Need for Control and Autonomy

For some South Asians, eating disorders have been linked to intrafamilial and intercultural conflicts (Furnham & Adam-Saib, 2001; Mumford et al., 1991; Mustafa et al., 2017; Reddy & Crowther, 2007; Varghese & Rae Jenkins, 2009). Intrafamilial refers to situations that arise within a family or household, whereas intercultural refers to the interactions or experiences between different cultures; as a result, South Asian families with traditional values often experience arguments between the children and the parents over traditional versus Western values (Varghese & Rae Jenkins, 2009). For example, studies by Mustafa et al. (2017) and Varghese and Rae Jenkins (2009) explored the rules and expectations around dating in South Asian and Western families. It was found that dating is natural and normal in Western culture before people decide to get married. However, this is negatively viewed by some South Asian parents because they do not believe in romantic or dating relationships before marriage (Bonfanti, 2015; Malla et al., 2022; Varghese & Rae Jenkins, 2009).

The pressures women of South Asia face, often living with dual cultural identities, can lead to significant internal conflict. This is particularly apparent when they seek greater autonomy in their lives, a theme highlighted in the study by Mustafa et al. (2017). These young women may resort to problematic eating behaviours, which can be understood as a coping

mechanism or a way of controlling their lives—a realm where their parents' influence may not extend (Mustafa et al., 2017). These behaviours may arise in response to conflicts within the family and between cultures. Instead of engaging in open dialogues with their parents about these conflicts, these young women might exert control over their bodies through indirect communication or resistance (Mustafa et al., 2017; Varghese & Rae Jenkins, 2009).

Numerous studies have identified internal control brought on by familial conflict (i.e., parents or older siblings) as a significant contributing factor to the emergence of eating disorders (Furnham & Adam-Saib, 2001; Mumford et al., 1991; Mustafa et al., 2017; Reddy & Crowther, 2007; Varghese & Rae Jenkins, 2009). Thus, women will try to gain control of their bodies through eating behaviours; ultimately, their desire for internal control and autonomy may manifest as eating disorders. However, some studies emphasized the notion that the psychological and sociocultural processes that trigger eating disorders are not fully understood and more research needs to be conducted (Bhatti, 2018; Mustafa et al., 2017; Pike & Dunne, 2015; Reddy & Crowther, 2007).

Field Journal #3

As I completed this capstone, I found talking within my circle of support about what I was encountering helpful. Many of the women I spoke with echoed similar sentiments to what I read in the literature. These are just a few of the anecdotes that they shared with me around the pressures that they felt in regards to eating and their bodies: “I did not know who I was or where I belonged because of the way that I looked;” “It felt like no one understood me, my parents would just laugh at me if I felt confident in the way that I looked;” “I always felt the need to please people by how much or little I ate, but never myself;” and “I will never feel like I am good enough no matter how much I try to change my body.” These are just a fraction of what

many South Asians in my circle have experienced. One of the biggest obstacles I have encountered in meshing my Canadian and Pakistani heritage intercultural conflict is that I always felt like there was an internal battle in my head. Growing up in a Westernized society, my cultural values always felt challenged by what I could and could not do. My white friends would be allowed to stay out late and have boyfriends, whereas that was unacceptable in my family. Through stories I have heard from my white peers, they could share their feelings, emotions, and concerns with their parents; however, that was an experience I felt I had lacked and yearned for. As I struggled, I craved that acceptance through my family, yet I felt all alone. I had turned to controlling my food intake to take that power back for myself, and there was nothing anyone could do about it. However, that process made me feel even worse about myself. I knew I could not continue living my life in a toxic cycle; instead, I had to learn to accept and appreciate my two identities and not punish myself through my relationship with food and my body.

Implications for Counselling Psychology

The insight gathered from the literature review highlights the need for more mental health interventions for girls and women from South Asian backgrounds to be rooted within the context of their cultural background. Clinicians must be cognizant of the cultural and societal factors that may lead to the underdiagnosis and underreporting of eating disorders within the South Asian population (Mammen et al., 2007; Mollah et al., 2018). A nuanced understanding of the role of gender, societal beauty norms, media influences, and the pressure of cultural conflicts can inform the strategy of more effective interventions and treatment methodologies. Striving to address dissatisfaction with body image, endorsing various aesthetic norms, and formulating culturally sensitive treatment methodologies are integral to supporting South Asian women in their journey towards healing from eating disorders (Goel et al., 2021). Furthermore, collaborative efforts must

be made to enhance consciousness and understanding of eating disorders and mental health within South Asian communities and among healthcare professionals. As a result, it will further help diminish associated stigma and improve access to appropriate mental health care (Willmot et al., 2022; Yasui et al., 2017).

These findings shed light on several implications for counselling psychology with South Asian women struggling with disordered eating. These implications highlight the importance of enhancing cultural competence, building trust and rapport, incorporating culture into assessment and diagnosis, addressing systemic barriers and cultural biases, and recognizing the role of family and community in treatment. These implications emphasize the need for clinicians to be aware of the unique cultural and social influences that shape the experiences of this population with eating disorders and to adapt their therapeutic approaches to provide culturally sensitive care (Yasui et al., 2017).

Enhancing Cultural Competence

Enhancing cultural competence in counselling psychology has profound implications for treating South Asian women struggling with disordered eating. Mollah et al. (2018) emphasized that cultural competence is about understanding different cultural norms and expectations and how these cultural contexts interact with mental health. Ma-Kellams (2014) suggested that non-Western cultural groups may express their distress in somatic presentations (i.e., cardiovascular symptoms or neurological symptoms) rather than psychological presentations, which can lead to a misdiagnosis if not adequately understood. Moreover, it is essential to recognize the influence of cultural values on the perception and manifestation of mental health symptoms (Sharma et al., 2020). This deep understanding can lead to more culturally informed and personalized treatment strategies, enhancing the overall effectiveness of therapeutic interventions (Moleiro, 2018).

The intersectionality of culture, gender roles, and societal expectations has become highly significant for South Asian women. The societal norms surrounding beauty, body image, and eating behaviours tend to arise from Western cultures, which are generally the default in many therapeutic contexts (Choukas-Bradley et al., 2021; Sadia et al., 2021). Given this notion, as emphasized by Thomas et al. (2016), it is crucial for clinicians to recognize and challenge their own cultural biases to enhance cultural competence. To combat cultural biases, clinicians must reflect on their assumptions and beliefs regarding eating disorders and be open to diverse cultural perspectives (Thomas et al., 2016). For example, in the Western context, eating disorders are often associated with body image, influenced by societal ideals. However, in South Asian cultures, the origin of eating disorders might stem from various factors such as familial pressures, intergenerational conflicts, or even somatization as discussed earlier. Thus, a culturally competent clinician would recognize and reflect on their initial assumptions that may be based on Western norms and open themselves up to the possibility that, within the client's cultural context, there could be different motivating factors at play (Sadia et al., 2021).

Additionally, engaging in continuous education and training is essential to improving cultural competence among mental health professionals (McGregor et al., 2019). By integrating regular cultural sensitivity training and supervision, clinicians can stay informed about cultural nuances and adapt their approaches accordingly (McGregor et al., 2019; Mollah et al., 2018).

Importance of Building Trust and Rapport

Building trust and rapport can significantly affect the therapeutic outcome when working with any population, such as women from South Asian backgrounds struggling with eating disorders (Bhatti, 2018; Nazir, 2015). As Meyer and Zane (2013) discussed, many clients have experienced marginalization and discrimination in society, which can lead to a lack of trust in

counselling professionals. Hence, establishing a solid therapeutic relationship characterized by trust and rapport is crucial for effective counselling (Lund, 2021), which can be particularly useful when working with South Asian women struggling with disordered eating. For example, a South Asian counsellor may find it easier to work with a South Asian client as they may have a shared understanding of the nuances of the culture (Moller et al., 2016). In contrast, a non-South Asian counsellor may find it more challenging to connect with their client (Moller et al., 2016). This notion is fundamental given the potential cultural and linguistic differences between the client and the counsellor (Meyer & Zane, 2013). Lund (2021) emphasized that fostering open communication within an understanding environment can encourage clients to share their experiences and concerns, creating a more effective treatment process. This way of being can be helpful when a non-South Asian counsellor is paired with a South Asian individual or an individual from a different cultural background from them.

Another foundation for building trust and rapport is cultural sensitivity and respect (Goel et al., 2021). Since not every counsellor will be of the same ethnic or racial background as their clients, clinicians must foster cultural sensitivity and respect by acknowledging their clients' cultural norms, values, and experiences; this includes understanding clients' cultural beliefs about their problem(s), the causes, and potential treatments, and avoid judgement (Mollah et al., 2018). Another crucial skill for building trust and rapport is empathetic communication and active listening (Roberts et al., 2015). A sense of trust and safety can be fostered as these skills demonstrate a genuine interest in the client and an understanding of the client's experiences (Roberts et al., 2015). Demonstrating compassion toward clients' struggles can validate their experiences and encourage them to be vulnerable about their experiences and struggles (Bhatti, 2018). Lastly, maintaining confidentiality and professionalism can significantly make a

difference in developing trust with clients. It is important to reassure clients that their private information will be protected and used only for treatment (Cohen et al., 2022; Moleiro, 2018).

Incorporating Culture Into Assessment and Diagnosis

Incorporating culture into assessing and diagnosing eating disorders among South Asian women is essential to effective treatment; it requires an awareness of cultural nuances and differences in symptom presentation. Ma-Kellams (2014) highlighted the critical role of somatic awareness, the conscious perception and understanding of one's bodily sensations, and the differences across cultures in relation to the manifestation and individual perception of eating disorders. As discussed previously, the manifestations of eating disorders, beauty standards, and perceptions of ideal body size may differ across cultures due to varying cultural norms and values associated with body image, food, and health. For example, non-Western cultures often present their distress predominantly through physical symptoms such as dietary changes leading to weight loss or physical discomfort following certain physical activities such as exercise or postsurgical procedures (Ma-Kellams, 2014). This can contrast with presentations in other populations, such as in Western cultures, where distress related to eating disorders may be more likely to be expressed through psychological symptoms such as an intense fear of weight gain or extreme dissatisfaction with one's body (Ma-Kellams, 2014). Thus, if these culturally specific expressions of distress are misinterpreted or overlooked, it could potentially lead to a misdiagnosis (Liang et al., 2016; Ma-Kellams, 2014).

Culturally sensitive interviewing techniques such as active listening, cultural humility, and validation can be powerful diagnostic tools as they account for cultural variations in presenting symptoms (Zhang et al., 2019). Furthermore, assessment tools and diagnostic criteria generally utilized for identifying eating disorders are primarily based on Western ideals and may

not fully capture the cultural specificities of South Asian or diverse populations (Bhatti, 2018; Mollah et al., 2018). The role of a clinician includes challenging cultural stigmas and stereotypes through education, awareness, and advocacy. Providing culturally sensitive psychoeducation to South Asian populations and other ethnic and cultural groups by validating and encouraging them to seek help and support can help reduce misconceptions regarding eating disorders (Hook et al., 2017; Mearns et al., 2013; Ratts et al., 2016). Therefore, assessment tools such as the Eating Disorder Examination (EDE-Q) and the SCOFF Questionnaire should be adapted and revised to be more culturally sensitive to provide a more nuanced understanding of eating disorder symptoms in different cultures, and diagnostic criteria to ensure a more accurate diagnosis.

Addressing Systemic Barriers and Cultural Bias

Systemic barriers can significantly impact the accessibility, quality, and effectiveness of mental health services. As a result, these factors may produce resistant or hesitant clients who lack counselling support (Hook et al., 2017). To promote social justice and fair access to mental health services, clinicians need to address these obstacles while working with this population struggling with eating disorders (Hook et al., 2017).

A systemic barrier is the limited availability and accessibility of specialized treatment for eating disorders and for those from ethnic minorities (Becker et al., 2010). As discussed by Bright et al. (2018), and Nazir (2015), South Asians in North America and the United Kingdom experience extreme difficulties in receiving proper care due to a lack of qualified specialists, treatment facilities, and a healthcare system lacking knowledge regarding eating disorders. Systemic barriers can be addressed by advocating for improved resources, funding, and specialized training programs tailored to the unique needs of South Asian and culturally diverse

populations. Moreover, collaborating with policymakers, healthcare organizations, and community leaders is vital as it can raise awareness regarding the prevalence and impact of eating disorders within South Asian communities (Mollah et al., 2018; Nazir, 2015). Furthermore, we must confront cultural biases within the mental health field, challenging Eurocentric norms (e.g., thin idealization, individual autonomy, and immediate symptom resolution) that may dominate eating disorder treatment and advocate for culturally responsive practices that resonate with the unique experiences of this population (Hook et al., 2017).

Another implication found in the literature review is cultural bias which refers to the tendency to prioritize certain cultural norms, values, and beliefs (Arredono, 2019), and financial status (Karasz et al., 2019), and can result in the misinterpretation of symptoms, misdiagnosis, and ineffective treatment plans for those from diverse ethnic and racial backgrounds (Kung & Johansson, 2022; Meyer & Zane, 2013). For example, cultural bias may arise in the assessment, diagnosis, and treatment of eating disorders in women from South Asian backgrounds by applying Western diagnostic criteria and conceptual frameworks that disregard the distinctive cultural context of South Asian communities (Pike & Dunne, 2015). As a result, it may result in incorrect diagnoses or the lack of recognition of culturally specific expressions of eating disorders (Goel, 2019; Shah, 2014).

To counter cultural bias, clinicians must strive for cultural competence by seeking a comprehensive understanding of diverse cultures (Mosher et al., 2017). Clinicians should aim to understand their values, traditions, and perspectives on food, body image, and mental health. This understanding can be deepened through continuous education, training, and active engagement with South Asian communities (Kung & Johansson, 2022). In assessments, culturally sensitive and validated tools can accommodate the unique experiences and

manifestations of eating disorders within South Asian communities. To achieve this, culturally relevant questions and considerations for how migration, acculturation, and intergenerational conflict can affect the development and presentation of eating disorders among South Asian individuals (Arrendono, 2019). Additionally, cultural bias can be mitigated in treatment by tailoring interventions to the cultural values, beliefs, and preferences of women from this population. To achieve this, integrating traditional healing practices (i.e., yoga and meditation, dietary adjustments, mindful eating, prayer, and recitation of religious texts), considering the significant role of family and community in the treatment process, and understanding the influence of cultural norms on body image and eating behaviour can further help combat cultural biases (Goel, 2019; Kung & Johansson, 2022).

Furthermore, collaboration with different ethnic group community leaders, cultural organizations, and religious institutions can contribute to combatting cultural bias by promoting mental health awareness, reducing stigma, and fostering culturally appropriate support networks (Mollah et al., 2018). By actively engaging with the community, counsellors can gain valuable insights into the cultural dynamics that impact South Asian women with eating disorders. Addressing systemic barriers and cultural bias allows clinicians to provide accurate assessments, appropriate diagnoses, and effective interventions that resonate with the experiences and needs of South Asian women struggling with disordered eating. As a result, this promotes quality of care and cultural humility, respect, and empowerment within the therapeutic relationship (Hook et al., 2017).

Role of Family and Community in Treatment

Family and community play a substantial role in treating girls and women of South Asian descent with eating disorders. They provide a crucial support system and can influence treatment

outcomes drastically (Erriu et al., 2020). Recognizing this dynamic in counselling can assist in creating effective, culturally appropriate intervention approaches (Acle et al., 2021; Erriu et al., 2020). Research indicated that in many South Asian cultures, family bonds and obligations hold meaningful importance (Bhandari & Titzmann, 2017 Patel et al., 2012; Shariff, 2009). Consequently, integrating families into the treatment process can enhance interventions' acceptability, appropriateness, and effectiveness (Couturier et al., 2020; Lock & Le Grange, 2019).

As suggested by Lock and Le Grange (2019), family-based treatment approaches have been identified as valuable techniques for managing eating disorders, allowing for the environment and relationships within the family to be assessed and addressed. Nonetheless, Varghese et al. (2020) proposed that the role of involving the family in the treatment process can be complex. While families can serve as a source of crucial support (Acle et al., 2021), they may also inadvertently reinforce or exacerbate the symptoms of eating disorders due to problematic cultural norms and expectations regarding food, body image, or weight (Lock et al., 2010; Wagner et al., 2020). Moreover, families may lack understanding about eating disorders, leading to stigmatizing attitudes, blame, or denial of the situation (Varghese et al., 2020). To combat this, clinicians can educate the family about eating disorders, their causes, symptoms, and impact, which is critical in addressing misconceptions or stigma. This psychoeducation should also highlight the complexity of eating disorders, emphasizing that they are not just about food or weight, but also relate to stress, control, self-esteem, and other emotional factors (Lock & Le Grange, 2019).

Thus, it is essential to respectfully include and understand the context of the client, their family dynamics, and when it is or is not appropriate to involve the family in the treatment

process (Lock et al., 2010; Varghese et al., 2020). Clinicians should be prepared to navigate these complexities and facilitate effective family involvement in supporting healing (Lock & Le Grange, 2019). By recognizing and understanding this influence, clinicians can enhance the effectiveness of their interventions, create supportive environments, and promote the well-being of this population.

Fundamental Steps for Future Research

Addressing the unique needs and experiences of South Asian women with eating disorders in counselling requires a multifaceted approach. This involves enhancing cultural competence, building trust and rapport, incorporating culture into assessment and diagnosis, tackling systemic barriers and cultural bias, and recognizing the significant role of family and community in treatment. These implications inform practice and guide the fundamental next steps in research. To further improve the understanding and care for girls and women of South Asian descent with eating disorders, it is paramount to further explore the prevalence and manifestations of these disorders in this population, develop and validate culturally specific assessment tools, evaluate the effectiveness of culturally sensitive interventions, conduct longitudinal studies on treatment outcomes, and enhance the training and supervision in multicultural counselling. These research choices emphasize a commitment to culturally sensitive, effective, and honest mental health care for South Asian women with eating disorders.

Prevalence and Manifestations of Eating Disorders Among South Asian Women

A fundamental next step for further research is continuing to add to the existing body of literature and research on the prevalence and manifestations of eating disorders among South Asian women. To build a more comprehensive and inclusive understanding of eating disorders, researchers indicate that there is a need to focus more on specific geographic contexts, such as

Canada and other populations beyond South Asians (Alegria et al., 2018; Egbert et al., 2022; Hossain et al., 2020; Shaw et al., 2012). South Asians make up one-quarter (25.0%) of all visible minorities in Canada, which equivalates to 4.8% of the overall population (Statistics Canada, 2018). However, the specific nuances of eating disorders among this population within the Canadian context have yet to be further explored due to cultural contexts, intersectionality, acculturation stress, stigma, and lack of awareness (Aujla, 2021). Thus, it is essential to conduct more region-specific research to understand the unique experiences of girls and women from South Asia in Canada, considering the influence of Canadian societal norms, migration stressors, and acculturation processes on their eating behaviours and body image perceptions (Bhatti, 2018; Karasz et al., 2019; Noor et al., 2020). Further exploration and research can help foster interventions that resonate with the specific needs and experiences of different cultural groups in Canada (Aujla, 2021).

Additionally, broadening the research scope to include other minority populations is crucial. As discussed previously, eating disorders are not exclusive to any one culture or ethnicity, and rather, they can impact any individual at any age or life stage (Coffino et al., 2020; Weissman, 2019). Therefore, studying the prevalence and manifestations of eating disorders among other groups can contribute valuable insights into the complex interplay of cultural, social, environmental, and psychological factors in developing these disorders (Coffino et al., 2020). This comprehensive approach can enhance the cultural competence of mental health practitioners and help develop interventions that respect and acknowledge the cultural diversity of those affected by eating disorders (Cachelin et al., 2001).

Longitudinal Studies on Treatment Outcomes

Another fundamental next step for further research is conducting longitudinal studies on treatment outcomes among South Asian women struggling with eating disorders. Longitudinal studies can provide valuable insights regarding intervention effectiveness and long-term impacts, allowing researchers to adjust treatment approaches and identify factors contributing to positive outcomes (Keel & Forney, 2013). Future research would benefit by focusing on developing and testing theoretical models, organizing focus groups to gather diverse perspectives, and exploring prevention models.

Karver et al. (2005) highlighted the value of longitudinal research in identifying factors contributing to positive treatment outcomes and guiding the refinement and improvement of intervention strategies. By establishing comprehensive theoretical models, researchers can enhance their understanding of the underlying mechanisms of change and identify effective strategies for improving treatment effectiveness (Atkins et al., 2017).

Lastly, exploring prevention models is vital for addressing mental health concerns before they escalate into more severe conditions. Singh et al. (2022) emphasized the need for longitudinal studies to inform evidence-based practices and enhance client care quality. Thus, by studying preventive approaches, researchers can identify risk factors, protective factors, and beneficial strategies for promoting well-being and preventing the onset of mental health concerns (Colizzi et al., 2020; Singh et al., 2022).

Culturally Specific Interventions, Assessment, and Diagnostic Tools

Developing and validating culturally specific assessment and diagnostic tools is fundamental in improving our understanding of girls and women of South Asian backgrounds struggling with eating disorders. Developing such tools requires an in-depth understanding of the

culturally specific factors affecting eating behaviours, body image, and self-image among South Asian women (Nazir, 2015). Furthermore, exploring the impact of migration, acculturation, and societal norms on these experiences can give clinicians a more profound understanding (Mearns et al., 2013; Pike & Dunne, 2015).

Western philosophies embedded in traditional assessments may fail to account for unique cultural beliefs, practices, and experiences within South Asian communities (Goel et al., 2021; Nazir, 2015), possibly resulting in inadequate diagnoses of these disorders (Gopalkrishnan, 2018; Prajapati & Liebling, 2021). Validation of these culturally specific assessment tools involves rigorous testing for reliability and validity in the specific population (Balachandran et al., 2022). Spivak-Lavi et al. (2021) emphasized the importance of developing versions of the Eating Attitudes Test (EAT-26), a widely used screening measure for disordered eating, that are sensitive to cultural differences and the shifting trends in the presentations of eating disorders. Additionally, the involvement of the South Asian community in the development and validation of these tools is crucial to ensure cultural relevancy and sensitivity (Balachandran et al., 2022). This participatory approach can provide valuable insights into culturally specific experiences and expressions of eating disorders that existing measures may not sufficiently capture (Blakemore et al., 2018).

Furthermore, evaluating culturally specific interventions is a fundamental step for further research. It allows for assessing their effectiveness, cultural relevance, and impact on mental health outcomes for diverse populations (Sue et al., 2009). Sue et al. (2009) emphasized the need for rigorous evaluation of interventions targeting ethnic minority populations. They argued that evaluations should consider the interventions' cultural relevance, practicality, and outcomes to ensure their effectiveness in addressing mental health disparities. Moreover, Perera et al. (2020)

highlighted the value of evaluating the cultural adaptation of interventions for diverse populations. Furthermore, Castro et al. (2010) demonstrated the need to assess the fit between the intervention and the cultural group and the impact on relevant outcomes for evaluating cultural adaptations. Thus, by systematically evaluating these interventions, further research can contribute to informing best practices and enhancing the need of culturally sensitive care.

Training and Supervision in Multicultural Counselling

As counselling psychology embraces diversity and cultural sensitivity, it is imperative to evaluate and improve training and supervision programs to meet the evolving needs of practitioners and clients (Cohen et al., 2022). A further research step should focus on evaluating the effectiveness of existing multicultural counselling training programs. Gonzalez-Voller et al. (2020) suggested assessing the outcomes of multicultural training programs regarding knowledge, skill development, and changes in attitudes among students. By examining the impact of multicultural training programs, researchers can identify areas of strength and further growth, leading to the improvement of curriculum and instructional methods (Harris et al., 2019; Killian & Floren, 2020). Additionally, by integrating diverse and engaging training experiences, counsellors can gain firsthand exposure to the lived experiences of various cultural groups, improving their ability to provide culturally sensitive and appropriate interventions (Gonzalez-Voller et al., 2020).

Lastly, supervision is another important area that requires further research. Supervision allows counsellors to receive guidance and feedback on their work with diverse clients (Wong & Wong, 2020). Adams et al. (2023) suggested that research should explore supervision models' impact on multicultural issues, including integrating cultural competence assessment and feedback in supervision meetings. Evaluating the effectiveness of multicultural supervision can

contribute to developing best practices and guidelines for supporting clinicians in their work with diverse populations (Wong & Wong, 2020). By evaluating and improving training and supervision programs in multicultural counselling, researchers can contribute to developing competent and culturally sensitive clinicians.

Recommendations for Clinical Practice

The application of clinical practice surrounding disordered eating among women of South Asian backgrounds requires a thoughtful and culturally sensitive approach. Given the cultural nuances that influence these resilient women's experiences, adapting the therapeutic process to their unique needs and circumstances is imperative. Several critical recommendations for practice have been identified to improve the effectiveness of care for this population. These recommendations encompass diverse aspects of the therapeutic process, from establishing a therapeutic relationship to the selection of therapeutic modalities to collaboration with community resources and addressing microaggressions. Each recommendation emphasizes the need for a culturally adapted approach that respects and honours the unique identities and experiences of South Asian women.

Enhancing Therapeutic Collaboration

One of the key recommendations for practice in working with South Asians struggling with disordered eating is to enhance therapeutic collaboration. Kazantzis et al. (2017) suggested that building a solid therapeutic alliance is paramount to effective treatment and can significantly impact treatment engagement, progress, and outcomes. Additionally, Mosher et al. (2017) indicated that adopting a collaborative and curious therapeutic stance can allow counsellors to work with clients as partners in the therapeutic process. Furthermore, given client diversity, clinicians can acknowledge clients' expertise in their own experiences and invite them to actively

participate in decision-making (Asnaani & Hofmann, 2012). This approach is essential for marginalized populations, who may often feel unheard or misunderstood, as it fosters a sense of empowerment and validates their lived experiences (Asnaani & Hofmann, 2012; Mosher et al., 2017).

Ridley et al. (2021) emphasized that counsellors should consciously consider including culturally specific factors in therapy. Research suggests that ethnic identity and acculturation can notably influence the development, presentation, and treatment of eating disorders among South Asian women due to the significant stigma surrounding eating disorders (Javier & Belgrave, 2019; Nazir, 2015; Pike & Dunne, 2015). Consequently, Acle et al. (2021) suggested that counsellors should strive to understand the client's ethnic identity and acculturation experiences and how these factors influence their eating disorder symptoms and recovery process. Similarly, Gainsbury (2017) recommended embracing the client's unique personal experiences and cultural background within therapy sessions can offer a more in-depth knowledge of their challenges and resources while providing a comprehensive and nuanced understanding of their mental health concerns. This includes discussing cultural norms and values, societal expectations, the impact of acculturation, discrimination, and cultural conflict on body image and eating behaviours (Acle et al., 2021). By discussing the impact of these factors, clinicians can foster a positive therapeutic relationship and further strive towards enhancing the therapeutic collaboration (Asnaani & Hofmann, 2012; Mosher et al., 2017).

Use Culturally Sensitive Assessments and Diagnostic Tools

Another important recommendation is to use culturally sensitive assessment and diagnostic tools to improve the care provided to individuals from diverse backgrounds (Awad et al., 2016). Sue et al. (2009) and Zigarelli et al. (2016) suggested that the clinical interview can be

made more culturally sensitive by integrating culturally relevant questions and discussions, such as exploring how cultural standards and beliefs impact perceptions of body image and eating behaviours (Javier & Belgrave, 2019; Mollah et al., 2018; Zigarelli et al., 2016). Similarly, Becker et al.'s (2003) study explored self-reported screening measures and the impact on ethnic minorities, and how the potential bias of clinicians can present a significant obstacle to obtaining appropriate care for eating disorder symptoms in diverse populations. Lastly, a cross-cultural study by Al Sabbah et al. (2009) proposed the need to adapt body image measures, such as the Body Shape Questionnaire (BSQ), to account for varying cultural ideals of beauty and body shape.

Thus, culturally sensitive assessment and diagnostic tools provide a more nuanced and authentic understanding of individuals' experiences and can allow clinicians to understand how cultural factors influence eating disorder symptomatology (Becker et al., 2002; Harris et al., 2019; Harris & Kuba, 1997; Talleyrand, 2006). Furthermore, Becker et al. (2010) suggested that it is fundamental that these culturally adapted measures are validated within each cultural group to ensure their reliability and accuracy in capturing the experiences of individuals from diverse backgrounds.

Tailoring Therapeutic Approaches

Tailoring therapeutic approaches to the specific needs of the individual client is another recommendation to foster effective treatment (Gainsbury, 2017). As Pike and Dunne (2015) discussed, tailoring therapeutic approaches involves developing a comprehensive understanding of each client within their cultural context. Similarly, Tewari et al. (2013) examined how culturally contextual factors such as intergenerational conflict, familial and societal expectations,

acculturation, religious or spiritual beliefs, and racism or discrimination may influence the development of eating disorders among South Asian individuals.

Moreover, clinicians can adopt a person-centred approach which includes striving to understand and validate the client's unique experiences and perspectives (Katz & Keyes, 2020). A person-centred approach involves active listening, empathy, unconditional positive regard, and demonstrating cultural humility and sensitivity (Mearns et al., 2013). This approach can help establish a solid therapeutic alliance with improved treatment outcomes as clients feel understood and accepted by their counsellors (Norcross, 2010). Furthermore, Nagayama et al. (2011) recommended that counsellors can benefit by integrating culturally specific therapeutic techniques into their practice. For example, acceptance and commitment therapy (ACT) can be adapted to incorporate cultural values and beliefs by promoting acceptance of difficult emotions, rather than trying to eliminate or avoid them (Nagayama et al., 2011). This approach can help clients cope with cultural or familial pressures and conflicts without resorting to harmful eating behaviours (Huber, 2020). Similarly, cognitive behavioural therapy (CBT) can be modified to address culturally specific cognitions and behaviours relating to body image and eating behaviours (Weingarden et al., 2011).

Collaborate With Community Resources

Another critical recommendation for appropriate care for girls and women of South Asian descent struggling with disordered eating is collaborating with community resources. Dueweke and Bridges (2017) expressed that psychoeducation helps explain mental health disorders, reduces stigma, and provides a more explicit understanding of eating disorders. Furthermore, Sharma et al. (2023) stated that psychoeducation can motivate individuals to seek help and embrace the treatment process. The literature revealed that psychoeducation can significantly

improve mental health literacy and reduce the stigma associated with mental health and help-seeking barriers among South Asian populations (Goel et al., 2022; Hassan et al., 2021). Given the research and the benefits of psychoeducation, collaboration with community resources can further help individuals who may be reluctant to seek treatment or unable to access mental health services due to cultural, financial, or other limitations (Castillo et al., 2019; Islam et al., 2023).

Castillo et al. (2019) suggested religious or spiritual organizations, educational institutions, workplaces, and healthcare facilities as potential resources for spreading psychoeducational information and leading educational events to further assist counsellors in collaborating with community resources. This can be accomplished by spreading informative flyers, organizing workshops or seminars, and creating digital resources on social media platforms on eating disorders tailored to ethnic communities (Albano et al., 2023; Goel et al., 2023). Prajapati and Liebling (2021) also proposed cultural healing practices and traditional support networks to be incorporated into the treatment process by involving community resources to preserve South Asian cultural identities. To achieve this, Pham et al. (2021) recommended working with religious heads or community elders to incorporate traditional religious or spiritual healing practices into therapy, making treatment more culturally sensitive and appropriate. Furthermore, future efforts should continue emphasizing the importance of community collaboration and psychoeducation to ensure culturally sensitive and comprehensive care.

Addressing Microaggressions and Microinvalidations

Addressing microaggressions and microinvalidations is another recommendation for practice. Sue (2010) defined *microaggressions* as “brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership” (p. 16).

Microaggressions can include subtly racist or prejudiced comments that perpetuate stereotypes or demonstrate bias (Luke, 2020). Sue et al. (2019) found that microaggressions were more harmful than non-raced-based insults since they lower individuals' social status in society. As discussed, microaggressions are not only limited to race, but can also range from gender, sexual orientation, disability, or mental illness (Sue et al., 2019). As a result, any marginalized group can be exposed to microaggressions (Luke, 2020). For example, a counsellor may attribute a South Asian client's struggles exclusively to their culture, thereby oversimplifying their experience and reinforcing stereotypes (Sue et al., 2009).

Similarly, *microinvalidations* are a type of microaggression which often take the form of dismissing or minimizing the experiences and feelings of individuals from minority backgrounds (Sue, 2010; Sue et al., 2019). For example, a counsellor might neglect the influence of cultural norms and beliefs or societal pressures on a South Asian individual's experience with eating disorders. This unintentional invalidation may lead to feelings of invisibility and a sense that their unique struggles are not acknowledged or understood (Luke, 2020; Sue et al., 2009). Clinicians need to develop cultural humility to effectively address microaggressions and microinvalidations, which includes recognizing their biases and the systemic inequities in healthcare settings (Hook et al., 2017; Mosher et al., 2017). To mitigate this, clinicians should engage in continuous self-reflection and education to understand the diverse cultural backgrounds of their clients (Nadal et al., 2014).

Moreover, Hook et al. (2017) suggested that counsellors should be open to feedback, actively involve clients in the therapeutic process by asking about their experiences with microaggressions and validating their experience, and acknowledge when they inadvertently perpetuate microaggressions or microinvalidations. This approach can help clients feel seen and

understood and build a stronger therapeutic alliance (Luke, 2020). Additionally, counsellors can help clients develop strategies to cope with microaggressions they may encounter. This could involve helping clients identify and challenge internalized negative beliefs, advocate for themselves, and build supportive networks (Nadal et al., 2014). Thus, by creating a safe and supportive therapeutic environment, clinicians can encourage more South Asian individuals struggling with disordered eating to seek and engage in treatment, thereby addressing one of the significant healthcare disparities that this minority population faces.

Culturally Sensitive Group Therapy

The final recommendation for practice is to include culturally sensitive group therapy for eating disorders among South Asian women. A meta-analysis by Grenon et al. (2017) suggested that group psychotherapy provides a unique and valuable platform for individuals struggling with eating disorders. Group therapy offers a sense of community and facilitates a safe and trusting environment for mutual support and shared understanding (Turpin & Shier, 2017). Nonetheless, Acle et al. (2021) proposed that group therapy must be culturally sensitive to benefit individuals with eating disorders. Furthermore, Sue and Sue (2012) recommended incorporating an understanding of the client's cultural context, including norms, beliefs, and values, into the therapy process to be more culturally sensitive.

Since the COVID-19 pandemic, the mental health field has shifted towards teletherapy, including online group therapy (Branley-Bell & Talbot, 2020). The aftermath of the COVID-19 pandemic has made mental health support and resources more accessible to individuals unable to participate due to geographical, transportation, financial, or scheduling limitations (Aafjes-van Doorn et al., 2021). For example, women from South Asian backgrounds living in a rural area of Canada might not have access to culturally sensitive group therapy in their local community.

Thus, online group therapy can bridge this gap by allowing women to connect with other South Asian or culturally diverse women with similar experiences (Acle et al., 2021) while fostering mutual understanding and reducing feelings of isolation (Asnaani & Hofmann, 2012; Flannery et al., 2021). However, some contraindications for online groups need to be considered and addressed. For example, the virtual environment may feel less personal or secure than a face-to-face setting, which can impact the development of trust and rapport within the group (Békés & Aafjes-van Doorn, 2020). Additionally, Pulat and Barutcu-Yildirm (2021) stated that privacy concerns can arise for individuals who may not have access to a private space to participate in the sessions. Furthermore, technology issues like unstable internet connections can interrupt sessions and disrupt therapy flow (Stoll et al., 2020).

Despite these challenges, research has suggested that teletherapy can be an effective and valuable tool when conducted appropriately (Gangamma et al., 2022; Robledo Yamamoto et al., 2021; Wiederhold, 2020). Strategies to mitigate potential disadvantages include setting group rules around privacy and confidentiality, providing technical support, and building rapport among group members outside therapy sessions (Connolly et al., 2020; Robledo Yamamoto et al., 2021). Ultimately, while online group therapy may not be the ideal solution for everyone, it can provide beneficial support and connection during challenging times for many individuals.

Reflexive Self-Statement

Reflecting on my personal and professional journey, I understand that my experiences as a South Asian woman have significantly shaped my perspective and fueled my commitment to serving individuals struggling with eating disorders. Growing up in a South Asian culture, I have been privy to the unique traditions, societal pressures, beauty ideals, and stigma associated with mental health issues that can influence a woman's self-image and relationship with food.

My experiences have given me an intimate understanding of the cultural context in which South Asian women navigate their lives. I have seen firsthand the consequences of the silence and stigma around mental health and eating disorders within our community, and this has instilled in me a deep motivation to break this silence and provide culturally competent care to racial and ethnic minorities, especially South Asian women. At the same time, I am continually conscious of the need to be aware of my biases and not generalize my experiences to all South Asian women. While our shared cultural heritage may provide a connection point, everyone's experiences, perspectives, and struggles are uniquely theirs. This understanding has highlighted the importance of maintaining a position of curiosity and openness in my therapeutic practice, seeking to understand each client's unique narrative within the broader cultural context.

My journey has also underlined the importance of self-care as an ethical imperative. As a South Asian woman navigating a patriarchal society myself, I am aware of the potential stressors and challenges that can arise. By practicing self-care, I ensure I can bring my best to my work, maintaining the resilience, empathy, and energy needed to provide appropriate care. By engaging with the hermeneutic phenomenology field journal, as a South Asian woman and mental health professional, I have experienced a deep personal and professional transformation. Reading the insights of experts in the field, reflecting on their implications for my practice, and seeing myself represented have affirmed my commitment to this work and my belief in the power of culturally sensitive, evidence-based mental health care. As I approach the end of my capstone paper, I would like to share one of my final field journals:

As a Canadian-Pakistani woman, my experiences have powerfully shaped my understanding and perceptions of the world, especially as they relate to my work as a counsellor. I have grown up in a culture filled with vibrant traditions and a strong sense of community, but

one that also grapples with a multitude of societal norms and expectations that significantly impact mental health, especially for women. Through my experiences, observations, and this capstone project, I have become acutely aware of how the silence around mental health issues, such as eating disorders, can be as harmful as the disorders themselves. I have endured the pain and struggle that comes from feeling like you must conform to a specific standard of beauty or societal expectation and how this can manifest into unhealthy attitudes and behaviours around eating and body image. However, my journey is about more than understanding these struggles—it is about helping to change them. As a clinician, I can directly address these issues, provide support, and challenge these damaging norms. It is a role that is sometimes difficult and often emotional, but one that I find deeply fulfilling. I am also aware that while my experiences as a South Asian woman can provide valuable insight, they do not encompass the full diversity of experiences within the South Asian community. Thus, I strive to listen more than I speak, learn from my client's unique experiences, and respect the nuances of their personal and cultural contexts. My experiences have highlighted the importance of self-care. Self-care is not selfish—it is an integral part of providing the best possible support to my clients. Ultimately, my experiences as a South Asian woman have deeply influenced my work as a counsellor. They have provided a firsthand perspective on the challenges many of my client's face, fueling my passion for supporting them. They have reminded me of the power of empathy, understanding, and cultural sensitivity. Moreover, they have emphasized the importance of continual learning, growth, and self-care in my pursuit to provide the best possible support for those in need.

Thus, as a South Asian woman and a mental health professional, my personal experiences have influenced my professional trajectory and served as a continual reminder of why this work

matters. I am eager to continue growing, learning, and contributing to the field, I strive to contribute to the field of mental health and make a lasting impact on the lives of those I serve.

Conclusion

This capstone project has highlighted the significant implications for research and practice in addressing the unique needs and experiences of South Asian women struggling with disordered eating in counselling. The complex nature of this topic requires a comprehensive and culturally sensitive approach to enhance understanding, develop effective treatment strategies, and improve the quality of care provided to this population.

The research recommendations discussed highlighted the importance of further exploration into the prevalence and manifestations of eating disorders among women from this population, the development and validation of culturally specific assessment tools, the evaluation of culturally sensitive interventions, longitudinal studies on treatment outcomes, and the enhancement of training and supervision in multicultural counseling. By pursuing these research endeavors, knowledge can be expanded, refine assessment and diagnostic practices, identify effective therapeutic interventions, assess long-term treatment outcomes, and enhance the competence of mental health professionals in providing culturally sensitive care.

The practice recommendations derived from the discussion highlighted the critical aspects of therapeutic collaboration, the use of culturally sensitive assessments and diagnostic tools, the tailoring of therapeutic approaches, collaboration with community resources, and the addressing of microaggressions and microinvalidations. These recommendations emphasize the importance of building strong therapeutic alliances, understanding the cultural context and the impact on eating disorders, utilizing assessments that are sensitive to cultural factors, adapting therapeutic approaches to meet individual needs, engaging community resources to enhance

support and education, and creating safe and validating therapeutic spaces by addressing forms of discrimination and invalidation. By integrating these recommendations into practice, clinicians provide effective and culturally competent care to diverse cultural groups struggling with disordered eating, ultimately promoting positive treatment outcomes and well-being.

Furthermore, the exploration of my personal journey as a South Asian woman professional in the mental health field serves as a reminder of the power of self-reflection in fostering empathy, understanding, and effective practice. The reflexive process is an ethical imperative, guiding our practice towards social justice, cultural competence, and effective self-care. Clinicians must continually engage in self-reflection, challenging their assumptions, and expanding on their cultural competence. The acknowledgement of cultural nuances, recognition of personal biases, the emphasis on empathy and cultural humility, and the importance of self-care exemplify dedication to providing ethical and competent care.

Ultimately, the goal is to create a therapeutic environment where South Asian women, and other diverse individuals, struggling with disordered eating feel heard, validated, and supported on their journey towards healing. By embracing the implications for counselling practice, fundamental next steps for research, and the recommendations outlined, clinicians can contribute to the advancement of knowledge. Furthermore, with a commitment to cultural competence, collaboration, and continuous growth, clinicians can contribute to a more inclusive and effective mental health care system that respects and honours the unique identities and experiences of South Asian women. Thus, while we have made progress in understanding and addressing the struggles regarding disordered eating among South Asian women, there is still much work to be done. This capstone project calls for the combined efforts of researchers,

clinicians, communities, and policymakers to ensure that mental health care is accessible, effective, and culturally sensitive for all who need it.

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