

**Mental Health Practitioners' Recognition of Disordered Eating in  
White and South Asian Patients**

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Submitted in accordance with the requirements for the degree of  
Doctor of Clinical Psychology (D.Clin.Psychol.)

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

June 2017

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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## Acknowledgements

I would like to thank my supervisor Professor Andrew Hill for his guidance, support and encouragement during this endeavour. Thanks also to Dr Suzanne Heywood-Everett for her input in the earlier parts of the project, and to Dr Gary Latchford and the late Professor Stephen Morley for their help in thinking about data analysis.

I am grateful to all those who took time out of their busy days to participate in this thesis, and in doing so not only supported this project but also raised money for very worthwhile causes. Thanks also to Priya and Jessica for allowing me to use their photos to show to lots of strangers! I also appreciate Dr Jaime Delgadillo encouraging the IAPT Practice Research Network to participate in this project, Ben Grigor for devising the randomisation weblink, and my peers for their helpful comments on earlier drafts of the survey.

I couldn't have completed this thesis without the help of my family and friends. They have supported and encouraged me and listened to many, many moans. A special thank you to my amazing parents and also to Iman, Ibrahim, Zainab and Amayah; you have no idea how much joy you bring your Khala.

## **Abstract**

Eating disorders are mostly prevalent in young females, with rates of disordered eating up to five times higher than diagnosable cases. There is evidence to suggest females from a South Asian background have higher rates of eating disorder symptomatology than their White counterparts. Culture plays a role in susceptibility to eating disorders, and factors such as parental control, stigma and ethnic stereotyping by health professionals can be additional barriers to seeking and receiving appropriate help. This thesis was concerned with the clinical decision-making processes of UK mental health practitioners and whether the ethnicity of clients affected this.

Three vignettes were devised, one including clinical features indicative of a restrictive eating pattern, one of a binge eating pattern and one with depression and anxiety symptoms. Each vignette was presented with a picture of either a young Asian female or a White female. One hundred and fifty six participants, all clinical staff in IAPT services, filled in an online survey comprising of one vignette and a questionnaire exploring factors involved in clinical decision-making and potential barriers to engagement.

Mental health practitioners were less likely to rate the vignette as showing symptoms of anorexia nervosa when the picture presented was that of an Asian female as opposed to a White female, and more likely to rate the Asian version with bulimia nervosa. There were no significant differences between ethnic groups in terms of treatment recommendations. Social and cultural factors were identified as areas of concern in the White vignette version, an unexpected finding.

These findings indicate there may be ethnic bias present in decision-making regarding eating disorders and disordered eating patterns. It is recommended training in both identifying eating disorder symptomatology and cultural competency is emphasised more in training courses and beyond. Further research into decision-making by mental health providers is also needed.

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## Introduction

### Overview of eating disorders and disordered eating

Eating disorders (anorexia nervosa, bulimia nervosa, binge-eating disorder and eating disorders not otherwise specified) are most common in young females in developed countries, with average prevalence rates of 0.3% for anorexia nervosa, 1% for bulimia nervosa and at least 1% for binge eating disorder (Hoek, 2006; Hoek & van Hoeken, 2003; Simon, Schmidt & Pilling, 2005). They have a significant negative impact on quality of life (Winkler et al., 2014). In the current version of the DSM (DSM-V; Diagnostic and Statistical Manual of Mental Disorders, APA, 2013), the main eating disorders are:

- Anorexia Nervosa – characterised by a distorted body image and excessive dieting with significant weight loss and a fear of becoming fat. This is achieved via the restriction of food and liquids.
- Bulimia Nervosa – characterised by binge eating plus compensatory strategies such as self-induced vomiting in an attempt to avoid weight gain. These behaviours must be exhibited at least once per week.
- Binge Eating Disorder – recurrent episodes of eating significant amounts of food in a short period of time than most others would eat, whilst experiencing a lack of control.

In addition to the above categories, there are DSM-V categories for Avoidant/Restrictive Food Intake Disorder (ARFID) and for Other Specified Feeding and Eating Disorders (OSFED). In this latter category are cases which cause significant distress but do not meet the criteria for the diagnoses above. Examples of this could be atypical anorexia nervosa, where all symptoms are met except the individual's weight is within a healthy range, or purging disorder, where purging to control weight occurs in the absence of any bingeing behaviours. Eighty percent of



cases of anorexia nervosa and 60% of cases of bulimia nervosa are referred on to secondary care (Turnbull, Ward, Treasure, Jick & Derby, 1996), meaning a significant proportion of both are managed in primary care via the GP.

Anorexia nervosa has the highest mortality rate of any psychiatric disorder, with annual mortality 12 times that of the general population (Sullivan, 1995). For the other eating disorders, there is less clear-cut evidence. Some have reported little evidence of increased mortality (Crow & Peterson, 2003; Nielsen et al., 1998), however a meta-analysis of 36 studies reported standardised mortality ratios of 5.86 for anorexia nervosa, 1.93 for bulimia nervosa and 1.92 for eating disorders not otherwise specified (Arcelus, Mitchell, Wales & Nielsen, 2011). Worryingly, they also found one in five individuals with anorexia nervosa who dies had taken their own life.

The thinness ideal is pervasive in society and media, leading to increasing dissatisfaction in growing numbers of females. A meta-analysis investigating the effect of thin media images on body satisfaction, perhaps predictably, found body image was significantly more negative after viewing thin media images than it was after viewing other body shapes (Groesz, Levine & Murnen, 2002). Among those for whom this effect was particularly strong were younger participants (under 19 years old).

Subclinical cases of disordered eating, where there is overlap with dieting behaviour but not to the extent of meeting full criteria for diagnosis, are estimated to be five times more common than fully diagnosable cases (Nasser, 2006). It is likely there are large degrees of impairment in this population but, due to lack of recognition or diagnosis, help is unavailable. The term 'disordered eating' has been chosen for this thesis to reflect such cases. This was due to a couple of reasons. Firstly, in recognition of these cases being more prevalent in the population and therefore more likely to be presenting to services, regardless of recognition of a problem in this area. And secondly, the participants in this study were mental

health practitioners (discussed later) in services which are diagnosis specific. Therefore people presenting to services would be likely to be put under a specific diagnostic category, which may or may not encompass eating disorder if there was recognition of disordered eating (as disordered eating in itself is not a diagnosis).

There is evidence to suggest disordered eating behaviours can remain constant over periods of time. A 10-year longitudinal study into dieting and disordered eating behaviours from adolescence to adulthood found prevalence of dieting remained constant for girls from adolescence to adulthood, as did unhealthy weight control behaviours (Neumark-Sztainer, Wall, Larson, Eisenberg & Loth, 2011). Extreme weight control behaviours increased for both sexes, however were higher in females, with 20% of young female adults using extreme strategies to control their weight.

In south east London, a community sample showed a high prevalence of disordered eating behaviours in the year prior to interview (10%, N = 164), the majority of whom were from an ethnic minority background (Solmi, Hatch, Hotopf, Treasure & Micali, 2014). Being of Asian ethnicity was associated with behaviours such as purging, loss of control eating and a preoccupation with food. The individuals who had disordered eating were also more likely to have comorbid conditions such as anxiety and mood disorders, addiction issues, post-traumatic stress and personality disorders, highlighting the importance of earlier detection and treatment pathways. Another UK study has placed rates of disordered eating at a prevalence of 6.3%, which is still higher than rates of reported eating disorders (McBride, McManus, Thompson, Palmer & Brugha, 2013).

Adding to this picture, eating disorders are often co-morbid with other mental health problems. For example, Kaye, Bulik, Thornton, Barbarich and Masters (2004) reported high rates of anxiety disorders in their sample of individuals with anorexia nervosa and bulimia nervosa, with the most common being obsessive-compulsive disorder and social phobia. A recent review and meta-

analysis found eating pathology and depression are risk factors for each other (Puccio, Fuller-Tsyzkiewicz, Ong & Krug, 2016). An older review (Holderness, Brooks-Gunn & Warren, 1994) identified substance misuse as more strongly associated with bulimia nervosa than with anorexia nervosa. It is therefore plausible that those presenting in health and mental health services may not present with an eating disorder, but with a comorbid disorder which is causing more distress and more significantly impacting on their life.

### **Ethnicity and how this is defined for thesis**

In this thesis, where the term Asian / South Asian is used, this is to refer to people whose ethnic background lies in the Indian subcontinent i.e. India, Pakistan, Bangladesh. This is differentiated from Asian as the commonly used American term for people from East Asia (which includes people from China, Mongolia, Korea, Japan and Taiwan). Black is used to describe people whose origins lie in Africa and the Caribbean, and Hispanic is used to describe people whose origins are from South America.

### **Disordered eating in different communities**

It was presumed for a long time that eating disorders were largely a White, Western female problem, however there is increasing evidence over the past couple of decades that this is not so. There is evidence to suggest eating disorders exist among different racial groups. In their study, Marques et al. (2011) looked at prevalence rates of eating disorders across different ethnic groups in the USA (Hispanic, White, Black, and East Asian). They found similar rates of anorexia nervosa and binge eating disorder across all groups but differing rates of bulimia nervosa, with this seemingly more prevalent in Hispanic and Black populations than White. Other American studies have found Hispanic women have eating disorders at least at a similar rate than White women, with others reporting higher rates of

binge eating but lower rates of anorexia nervosa and bulimia nervosa (Alegria et al., 2007; Granillo, Jones-Rodriguez & Carvajal, 2005). In addition, Mulholland and Mintz (2001) found similar rates of binge eating disorder in Black and White women.

There is also growing evidence against the long-held view that eating disorders are solely a Western problem, with eating disorders increasingly reported in a range of countries across the world (e.g. Nasser, 2006). For example, in a study looking at body image in Pakistani and Australian female university students, it was found that although the 'ideal' body shape was similar for participants, the Australians were overall more dissatisfied with their body image (Mahmud & Crittenden, 2007). This suggests there is a cultural element to body image dissatisfaction, which can be either protective against or exacerbate negative self-image. This also challenges the assumption of eating disorders largely being confined to a specific ethnic group. It becomes apparent that trying to identify rates of eating disorder by ethnic group is a complex issue. Other reviews have reported on the rise of eating disorders in different countries in Asia and also the impact of changing culture on our understanding of this as a global issue (Pike & Dunne, 2015; Pike, Hoek & Dunne, 2014).

Publications in cross cultural aspects of eating disorders have increased over the past few decades. Soh and Walter (2013) reviewed publications from 1970 to 2011 and found that from 4 articles being published in 1970-4, there was an increase to 427 in 2004-9. African and Black Americans were the subject of most studies, with Pacific Islanders and Southern Europeans the least. This indicates growing recognition of and attention being paid to this area. However, it cannot be assumed that findings from one culture will be applicable to others, and when broken down this research field is still very small by ethnic group.

## **Search strategy**

A search for relevant literature for the following sections was conducted using databases (PsychInfo, Medline and Scopus) and a search on Google Scholar. Combinations of the following keywords were used to search for relevant articles:

Eating disorders, eat\*, anorexia, anorexia nervosa, bulimia, bulimia nervosa, binge eating disorder, BED, eating disorder otherwise specified, disordered eating, Asian, south Asian, Pakistan\*, India\*, Bangladesh\*, clinical decision-making, stereotyp\*, bias\*, mental health, cultur\*, IAPT, vignette, ethnic\*, rac\*, parent\* control, parent\* conflict, stigma.

Relevant articles were identified by reading abstracts and the reference lists of these articles were also used to identify further useful material.

## **Disordered eating and eating disorders in the UK Asian population**

Rather than considering disordered eating or rates of eating disorders in all ethnic groups compared to White, this thesis focussed on the research available on Asian populations. Where possible, UK studies have been used as this thesis was specific to the UK population. However, where there was very limited UK literature (e.g. in area of bias), American studies in similar areas were also used.

The noticeable absence of ethnic and cultural issues being addressed in the field of eating disorders has been observed for over two decades by UK researchers (e.g. Ahmad, Waller & Verduyn, 1994; Dolan, 1991; Dolan, Lacey & Evans, 1990). Dolan's (1991) review of the cross-cultural aspects of anorexia nervosa and bulimia nervosa found there were no reports in the literature of non-White women with eating disorders in the UK until as recently as 1985, when Thomas and Szmukler reported on 3 Black patients with anorexia nervosa at a specialist eating disorder centre.

In the UK, it has been reported that there are high rates of disordered eating in South Asians, higher even than their White counterparts. Using a questionnaire and interview method, Mumford and Whitehouse (1988) were one of the first UK group of authors to highlight potentially higher prevalence rates of eating disorders in Asian females in Bradford, specifically bulimia nervosa, which was an unexpected finding possibly due to the limited literature in this area. They concluded, *“This change suggests that Asians are increasingly adopting Western patterns of reacting to stress. Our finding of a higher prevalence of bulimia nervosa would seem to be a parallel phenomenon and highlights one difficulty facing Asian schoolgirls growing up in Britain”* (p.718).

A follow-up study found similar results (Mumford, Whitehouse & Platts, 1991) and postulated this to be due to a number of different factors, such as adopting ‘Western’ ways of managing distress, conflict around issues of cultural identity, and intergenerational conflict. The Asian girls who used Asian language and dress more also scored higher on the Eating Attitudes Questionnaire (EAT; Garner, Olmsted, Bohr & Garfinkel, 1982) and the Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper & Fairburn, 1987), which suggested a more traditional cultural orientation rather than a Western one may be influencing internal conflict and distress management. Also in Bradford, Hill and Bhatti (1995) found Asian 9-year old girls expressed a desire for thinness at least on par with their White counterparts, and there was a link between reported dieting behaviour and family culture, with those girls reporting greater body dissatisfaction and esteem more likely to come from more traditional Asian families.

Furnham and Patel (1994) had also investigated eating attitudes and behaviour in British schoolchildren, comparing White and Asian girls aged 12-18. They did not find significant differences between the two groups in terms of eating attitudes or vomiting behaviours. What was found to be different was there was evidence of some cultural differences, with the Asian sample’s scores being linked

to wider questions around resentment over restriction of choice in areas such as marriage and going out whenever they pleased.

In a study using questionnaires and interviews to survey teenagers about eating habits and bulimia nervosa, Bhugra and Bhui (2003) suggested Asians were suffering more from abnormal eating behaviour than the White or Black population. Fasting was also suggested as a method of controlling weight, with it being acknowledged this is a religious obligation in many Asian religions.

In light of the above, there has been growing evidence over the past few decades of differing rates of eating disorders and disordered eating in young Asian females as compared to the majority White population. The next section turns attention onto whether this disparity is also clear in services where people would be expected to go for help.

### **Access to services**

Dolan's (1991) review identified that in any interaction between the minority groups included in the literature on eating disorders, there were two cultures; one was that of the patient and the other of the professionals and services providing help. If there is a common perception that eating disorders are uncommon in minority groups, *"it may be that primary health care agencies do not recognize, or fail to diagnose, anorexia nervosa and bulimia in these groups"* (Dolan, 1991, p76).

The difference in rates and recognition of disordered eating in Asian populations is apparent when looking at services. Ratan, Gandhi and Palmer (1998) found a disparity in rates of eating disorder presentation at a specialist clinic in Leicester between Asian and White patients, with Asians presenting at a rate of around a quarter of that of the White population. Their conclusions suggested either there was a noticeable difference in the rates of eating disorders among

Asians, a finding not backed up by the literature, or that there were obstacles in finding specialist care such as being less likely to be considered for referral to specialist services.

This was a different finding than that of Button, Reveley and Palmer (1998), who used a questionnaire and vignette design to investigate health perceptions and help-seeking behaviour in young women aged 18-27 years from different ethnic groups in Leicestershire. One of the vignettes depicted a physical health problem (headaches), one a psychological problem (depression) and the final one disordered eating behaviour. Although just under half of the postal questionnaire booklets were returned, the authors did look at demographics of non-respondents and concluded there were no significant differences in terms of age or ethnicity; the same went for the responders group. The authors found there was little significant difference in eating attitudes and behaviour in the ethnic groups they had selected (in this case White, Asian, Black and 'Other' including Chinese origin). It was of note that White women were found to have the highest rates for forms of weight control examined, with 11.5% having used vomiting as a form of weight control compared to 1.4% of the Asian women and none of the Black women. This was the only significant difference. One reason this could be less common in the Asian group was due to living situation. As Asians are more often likely to be living with someone, whether partner or family, it may explain why they would be less likely to use vomiting as a form of weight control due to the fear of being found out. There were no significant differences in health-seeking behaviour between ethnic groups.

The authors acknowledge these findings are not consistent with other studies. One reason could be that some of those studies were based in clinical populations, whereas the sample for this study came from an ethnically diverse community population who were selected to receive questionnaires via a GP practice. Other differences could be due to religious factors (with the largest religious group in the Asian category being Sikh in this study and Muslim in others)



and also immigration status. The majority of the Asian group in this study were UK-born but this is not the case in some other studies (e.g. Dolan et al., 1990) and could potentially impact on understanding of and rating on questionnaires in English.

Retrospectively comparing case notes of Asian and matched White female adolescents who had presented at psychiatric clinics with symptoms of anorexia nervosa, it has been found that Asian females were significantly less likely to receive a diagnosis of anorexia nervosa (Tareen, Hodes & Rangel, 2005). Symptom profiles between the two groups also differed, with the Asian adolescents, *“more likely to describe loss of appetite and are less likely to describe fat phobia or exercising to lose weight compared with their White British counterparts”* (p.163). This suggests practitioners may need to be aware of differences in presentation of disorders between ethnic groups as the standard list of symptoms on which diagnoses are based may be biased towards White, Western populations. In addition, stereotyping may play a role in diagnoses considered, which will be discussed in a later section.

The low rates of minority patients presenting for help relative to their numbers in the population was also a finding by Waller et al. (2009), who compared ethnic background of patients presenting at eating disorder services in South London, a very ethnically diverse area. The study differentiated between ethnicity by South Asian, White and Black (however in the analysis of diagnosis and treatment offered, the categories used were White and non-White). This study found that overall, the White population was over-represented by 25% in referrals to services. One such reason for this could be that, *“cases are not being identified in primary care, and hence are not being referred through to the specialist services”* (Waller et al., 2009, p.462).

Characteristics of Asian patients referred to a specialist eating disorders service in Leicester were compared to non-Asians over a 15-year period (Abbas,

Damani, Button, Aldridge & Palmer, 2010). It was found Asians were under-represented in the service compared to their makeup in the local population, stating that overall, *“the rate of referral for the Asians is about a third of that expected”* (p. 407). This study did not find significant differences in clinical features between Asian and non-Asian patients. It was postulated that the reason for low rates of referral could be due to two reasons. One, that Asians in Leicester were less likely to be referred to services as they were less likely to have an eating disorder, perhaps due to cultural factors such as differences in ideal body shape. Acknowledging this did not fit with the little existing literature there was in the area, a second possible explanation was that factors such as stereotyping, prejudice, shame and different ways of understanding problems may be making it more difficult for those from an Asian background to be referred to specialist secondary services.

It should also be noted that the above study focussed only on those with disordered eating meeting a clinical range and able to meet criteria for diagnosis. Therefore, 17.5% of the referrals were excluded from comparison. Due to the low number of Asian patients with anorexia nervosa, the comparison excluded this group and only used a diagnosis of bulimia nervosa and EDNOS (eating disorder not otherwise specified). In addition, low numbers of participants in the groups compared meant that in general there was insufficient statistical power to detect anything other than a large difference.

From the discussed literature, it appears that there are discrepancies in two main areas– one in the prevalence of disordered eating symptomatology in Asians versus the White populations, and the other in equitable access to services.

## **Factors affecting recognition and help-seeking**

Interpreting the different rates of disordered eating and eating disorder pathology found between Asian and non-Asian populations and how this can impact on service access, many of the research papers mention cultural/cross cultural factors as playing a role. This makes sense, as some findings have found Asian females from more traditional backgrounds may be more susceptible to eating disorders. However this explanation may also be overly simplistic.

*“Culture is an anthropological term, defining a complex whole that includes the knowledge, behavior, morals, customs, and often religion. Culture is acquired by being and/or growing up as a member of a society or a social group” (Dolan, 1991, p.75).*

Rather than considering how culture as a whole can have an impact, clinically it may be more useful to consider specific facets of culture which have a differing impact on minority groups, in this case Asian.

There are a number of factors which could influence the development of disordered eating and help-seeking behaviour. For the purposes of this thesis, three areas will be covered: parental control, stigma and stereotyping. The focus will be on three different areas (home, community and health services) where barriers to recognition of a problem and accessing help can exist.

### Parental control

*“Parents are likely to attempt to ensure that their children conform to the values that the parents themselves hold as important. These efforts will conflict with their child’s attempts to identify with Western influences (e.g., peers) and with norms that are less centered on obedience to parents” (McCourt & Waller, 1995, p.278).*

Parental control can understandably have a significant impact on young people and feasibly play a role in the development of eating disorder psychopathology. There is some implicit suggestion in the studies already mentioned that girls from an Asian background may be subject to greater degrees of parental control. This section focusses on the research in this area more explicitly.

Compared to their White peers, Asian schoolgirls have been found to perceive their parents as more controlling as measured on the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979) and it was, *“particularly worth noting that the level of bulimic attitudes among the Asian girls was correlated with higher levels of maternal control”* (Ahmad, Waller & Verduyn, 1994, p.94). This finding has also been reported when age category is considered in addition to ethnicity (i.e. 12-13yrs, 14yrs and 15-16yrs), with Asian girls having significantly less healthy attitudes towards eating than their White counterparts (McCourt & Waller, 1995). This difference could in part be explained by scores on the PBI, with mothers being perceived as more controlling, a perception that appeared to develop between 12-16 years, perhaps when young girls are most susceptible to peer and societal pressure and least able to gain as much independence or autonomy as they desire.

Furnham and Husain (1999) devised a Parent Conflict Questionnaire, comprising 4 main areas (role of women, marriage choices, going out and choice of friends), which were administered along with the Eating Attitudes Test (EAT-26) and Parental Bonding Instrument (PBI) to White and Asian female undergraduate students in London. The EAT scores found in this study were also compared to those in Mumford, Whitehouse and Platts (1991), Ahmad, Waller and Verduyn (1994) and McCourt and Waller (1995). Contrary to the earlier studies' findings, there were no significant differences in eating attitudes as measured by the EAT-26. However, scores on the PBI were significant in that maternal and paternal

overprotection scores were significantly higher for the Asian students than the White students, as were scores in all 4 areas of conflict.

One reason suggested for the different findings in eating attitudes in the above study was age of participants, with them being over 18 in this study compared to younger schoolgirls in the previous ones the findings were compared with. Eating attitudes may shift with age and stage of life. Another reason could be that different communities, settling in different areas of the UK, may have different demographics, attitudes and culture that can't easily be compared to others. An oversimplification of distress processes could be made which may not be applicable for a large proportion of the group. It also ignores the impact of religious practices, which can potentially have an impact on eating aetiology, as India is a Hindu-majority country but Pakistan and Bangladesh are Muslim-majorities.

Looking at the sociocultural factors impacting on eating in Asian females, there were two highlighted and distinct areas reported where second generation women faced problems (McCourt & Waller, 1996). One was acculturation, where the norms of the host (in this case Western) society were absorbed and adopted, in this the value placed on thinness as an ideal body shape. The second area is 'culture clash', where control issues arise as a result of two cultures that can have conflicting ideals. Parents may want the young person to follow their more traditional path however the young person, caught growing up in a different world, may feel trapped between two worlds with little say in many areas.

Splitting 'Asian' into categories by country of origin can yield interesting results. A replication of the Furnham and Hussain (1999) study recruited from secondary schools and a youth group and split participants into country of origin (Indian, Pakistan and Bangladesh) and focussed on factors they felt were specific to eating disorders in Asian girls who were second generation immigrants in England – acculturation, culture clash, and perceived parental control (Furnham & Adam-Saib, 2001). The EAT-26 and PBI were two of the measures also used. Overall, the EAT

scores in the Asian sample were significantly higher than in the White sample, however bulimic attitudes reported as higher in earlier studies was not supported here. The Bengali sample had significantly higher total EAT score and dieting scores than the other 3 groups (Pakistani, Indian and White), whereas the hypothesis had been that both the Bengali and Pakistani samples would have higher scores than the Indian sample. Parental overprotection scores were also significantly higher in the Asian group (with no differences between subgroups, however a surprising finding was that parental care scores were significantly lower in this group than the White group). There was also no significant association between EAT and PBI scores across the groups. The fact that as a whole the groups have higher scores in some areas but also individually have different scores points to there being common factors in all but also enough difference to distinguish between groups.

Age is also a factor. These studies used samples of teenage girls. On the one hand it may be that Asian parental overprotectiveness decreases as their daughters get older. On the other, parental control may increase as their daughter becomes of marriageable age (Furnham & Adam-Saib, 2001). It can be difficult to untangle the myriad of factors that separately and collectively affect these groups. Suggestions for areas of importance are social class, religion or education, however it is of note that the literature in this area is again very small.

Differences in parental control and eating psychopathology can also hold true when comparisons are made between groups of similar origin across countries. A comparison of the relationship between eating attitudes, parental conflict and over-protection in 3 separate cultures (White British, second generation British Asians from Pakistan and Pakistanis in Pakistan) showed British Asians had significantly higher scores on the EAT than the other two groups (Mujtaba & Furnham, 2001). Surprisingly, the Pakistani group's score was significantly higher than the White British score, which undermines the assumption that they would have had less exposure to Western ideals on slimness. British Asians also perceived their parents as more overprotective and restricting of their

independence than the other groups, followed by the Pakistani group. The negative association between overprotection and conflict scores for the British Asians illustrated the greater the level of conflict, the more the women perceived their parents as overprotective. *“British Asian females have a different transition in to adulthood than most white females because of the added stressors of parental conflict and perceived parental overprotection, which could predispose them to develop an eating disorder”* (Mujtaba & Furnham, 2001, p. 33).

Overall, it appears parental control can play a significant role in eating disorder psychopathology, with the evidence stronger for maternal control. What is unclear is whether disordered eating attitudes develop as a result of increased control, or the opposite; parental control increases in light of the development of disordered eating attitudes in their teenage daughters.

Studies have also tended to use different rather than similar age categories when exploring similar concepts, which may explain some variation in findings. Developmentally there are big differences between teenagers, and perhaps more when compared to people even older. The most recent study mentioned above is also 16 years old and it is feasible that cultural attitudes, expectations and assimilation in 3<sup>rd</sup> and 4<sup>th</sup> generation British Asians are different to those suggested in these studies. However, without further research in this area it is not possible to comment on the extent of any changes or shifts in attitudes and their impact that may have occurred in the past couple of decades.

#### Impact of stigma on help-seeking

Despite the increasing availability of mental health treatments available on the NHS, there is evidence to suggest that less than half of the population that could make use of services are accessing them for help (Andrews, Sanderson, Slade & Issakidis, 2000; Brown et al., 2014). What appears to be more common is help-seeking via informal means such as friends, family and community, which are

difficult to evaluate. It is feasible for some conditions that informal help may be most beneficial and respond well to support from those close to the person. For others, however, delays in seeking help can have serious negative repercussions, for example being linked with worse outcomes e.g. in people with psychosis or those with depression and anxiety disorders (Boonstra et al., 2012; Dell’Osso, Glick, Baldwin & Altamura, 2013).

Mental health stigma can play a big role in whether people access help. A recent systematic review investigating the impact of stigma on help-seeking using research until 2011 found stigma was one of the main barriers identified which stopped people accessing services (although it was not the top one, which was disclosure concerns). Some populations, such as ethnic minorities, men and younger people were also evidenced to be disproportionately impacted by stigma (Clement et al., 2015).

Community findings using data from the South East London Community Health study (SELCoH) have yielded similar results, with family and religious leaders sought out for help twice as often as formal help (with the majority of people who used formal help also using informal help), men being less likely to seek help than women, and younger people more likely to use informal support whilst older groups were less likely to access any support at all (Brown et al., 2014). Clinical factors in terms of complexity or severity were more likely to impact on the decision to seek help than differences by ethnic or social background.

In terms of eating disorders, specific barriers that stopped adult women with bulimia nervosa-type eating disorders accessing help related to personal motivation, fear of stigma and (because of a different healthcare system in Australia than the UK), the cost (Evans et al., 2011; Hepworth & Paxton, 2007). There was evidence that a positive experience could be provided, for example by having an empathic and helpful healthcare professional, which could then impact on future help-seeking behaviours. The first person to whom women sought



formal help was their general practitioner (GP). Although a different, nationalised healthcare system is in place in the UK, the GP is usually the first point of call for many people as it is from there that referrals to most other services can be made.

It should be noted that differences in healthcare systems can be a significant challenge which may make international comparisons difficult. For example, an American study seeking to examine barriers to eating disorder treatment in ethnic minority women found the main barrier to seeking treatment were financial reasons (Cachelin, Rebeck, Veisel & Striegel-Moore, 2001). This is less likely to be the case in the UK.

Focus groups in Leicester have reiterated many of the themes highlighted in previous studies – a positive view of thinness, lack of understanding of knowledge about eating disorders, the stigma associated with mental health problems and concerns about confidentiality, etc. that serve as barriers to help-seeking for eating disorders among Asians (Wales, Brewin, Raghavan & Arcelus, 2017). It is clear barriers to accessing services are multifaceted and not only due to difficulties when services are accessed. *“The ego-syntonic nature of core eating disorder symptoms, such as severe weight loss or purging (at least in the early stages of the illness), may interfere with an individual’s willingness to seek treatment”* (Becker, Arrindell, Perloe, Fay & Striegel-Moore, 2010, p. 633). In addition, fear of stigmatisation, shame and also fear of stereotyping can also stop minorities with eating disorders from accessing help (ibid).

In Asian cultures, traditional values in terms of keeping problems within the family, conformity and emotional restraint may make it more difficult to have conversations about one’s problems with ‘outsiders’ (Das & Kemp, 1997; Vogel, Wester & Larson, 2007). In addition, there can be differing understandings as to the cause and role of mental illness which differ from Westernised concepts, such as punishment from God, or from previous lives, or some fault in your makeup (Fogel & Ford, 2005; Jobanputra & Furnham, 2005; Raguram, Raghu, Vounatsou &

Weiss, 2004).

In a recent American study, Arora, Metz and Carlson (2016) sought to explore the roles of perceived (by community or close ones) and personal stigma on attitudes towards professional psychological help-seeking and their effects across gender in second generation South Asian students aged 18-22 years. Using online questionnaires to measure stigma (perceived and personal) and attitudes towards professional help-seeking, the authors found personal stigma (but not perceived stigma by close others) was negatively associated with attitudes about psychological help-seeking. This finding has also been reported previously (Loya, Reddy & Hinshaw, 2010) therefore it is not only stigma from service providers that can be a barrier to accessing help, but from the individual and those around them too.

Negative attitudes have been found to be stronger in males rather than females, which may be linked to traditional gender roles. Female Asian students in London have been found to hold more positive attitudes towards psychological help-seeking than men, and adherence to cultural values, ethnic identity and cultural mistrust were negatively associated with help-seeking, with ethnic identity being the strongest predictor (Soorkia, Snelgar & Swami, 2011). This is in keeping with other research and also relates to wider areas beyond the scope of this review, such notions of masculinity and links to health-related behaviours.

The impact of stigma can be wide-ranging and not just confined to the individual's decision to seek help. Asian families in Scotland reported the stigma of being identified as having a mental health problem and the fear of gossip, even from those close to you, as some of the main reasons that dissuaded them from accessing help from Child and Adolescent Mental Health Services for their children (Bradby et al., 2007). Themes around family matters being kept private and mental illness and services working in this area being seen as shameful also came up. The concept of maintaining '*izzat*' (honour) was prevalent and could also be linked to

other factors such as effect of labelling on one's family and future marriage prospects. Some of the difficulties the researchers encountered included peoples' reluctance to be involved in the research or even speak of these issues. This is in contrast to many of the studies that have been published in this area, who have often used student populations. While this is an easier and also more convenient participant pool to access, it may not accurately reflect the people who do come and engage with services (or not).

### Ethnicity stereotyping by health professionals

Common misconceptions exist in many areas and can be pervasive, such as the long-standing belief that eating disorders are a White, Western problem. Such stereotypes can have negative consequences for particular groups, such as the Asian population highlighted above, where recognition and treatment is influenced by the background of client.

In terms of eating disorders, there may be an additional factor involved in terms of professional from whom help is sought. Hay, Darby and Mond (2007) investigated mental health literacy around Bulimia Nervosa in health professionals. Using a vignette and questionnaire method, participants (dietitians, psychologists and counsellors) were asked to complete an online survey regarding a young woman with bulimia nervosa. Almost half of participants correctly identified the woman was suffering from bulimia nervosa, with an eating disorder the second most chosen response. Dietitians and psychologists were more likely to be correct than counsellors, and overall this raises the concern around mental health literacy around eating disorders in non-specialist primary care healthcare providers. An earlier study by some of the same authors (Hay, de Angelis, Millar & Mond, 2005) had used a similar approach with GPs, of whom 95% identified the problem as an eating disorder and around half specified bulimia nervosa. Eighty percent felt discrimination would occur if others knew of the problem and the majority also felt it was a severe disorder and difficult to treat.

In another British study with GPs, again using vignettes, Currin, Schmidt and Waller (2007) hypothesised certain characteristics (i.e. being White, being female) would make it more likely that a patient would receive a diagnosis of an eating disorder. However, it was found ethnicity of the patient did not influence diagnosis given (although not statistically significant, there was a tendency for Black patients to be given a follow-up appointment and for White patients to receive a referral directly to a mental health service). Gender was a significant factor. Females were more likely to be given an eating disorder diagnosis and males more likely to be diagnosed as depressed. The professionals' personal characteristics, such as their own gender, were not found to significantly influence the results. There was also a pattern of physicians working in urban areas being more likely to prescribe antidepressants. This was perhaps due to the populations they served being more likely to have limited social contacts and therefore a medical intervention being preferential rather than a psychosocial one. Interestingly, less than 70% of the vignettes were given a primary diagnosis of an eating disorder, despite the vignettes being designed to represent eating disorder cases. This raises important questions about the number of people who in general practice may be missing out on access to much-needed services because their problems are not being picked up in primary care.

Also in the above paper, multiple variables were manipulated in the two vignettes – gender, ethnicity, BMI and comorbid medical condition. Participants were asked to then select a probable diagnosis, course of treatment, and timeframe for course of action. What was not measured, and then later inferred, was *how* clinicians made their decision i.e. which factors / symptoms in the vignettes led to their decisions. There was also no control case to compare across disorders. The authors also acknowledge that due to a prior audit, participants were not blind to the topic of interest to the researchers and this could have had an impact on diagnoses made and treatments selected.

In the USA, vignette studies have helped highlight race-related bias in mental health practitioners, with White and Hispanic girls more likely to be identified as potentially having an eating disorder than if the example was Black, in which case they were also less likely to be referred for help (Gordon, Brattole, Wingate & Joiner, 2006). Another interesting finding was that *ability* to identify symptoms of an eating disorder was not influenced by race, but *conceptualising* them as an eating disorder was less likely when the vignette was of the Black girl. The authors concluded racial stereotypes could be leading to reduced recognition of eating disorder pathology in Black girls. It should be noted that the majority of clinicians participating in the study were White and it would have been beneficial to be able to compare if own ethnic background was linked with similar stereotypes, especially if the clinician was of a similar ethnic background as the vignette. It was also acknowledged other factors could play a role in the differences found, such as access to healthcare and different cultural presentations of disorders and that highlighting tendencies to stereotype may help in combating this issue.

These stereotypes in relation to eating disorders are not limited to healthcare providers but also appear to be prevalent in student populations. Vignettes of White characters led to a significant increase in recognition of an eating disorder than when the character was Black or Hispanic (Gordon, Perez & Joiner, 2002). Interestingly, participant variables such as gender and ethnicity were not found to impact on recognition, meaning potential stereotypes exist regardless of one's own background. This finding has been contradicted however, with results of another vignette study showing recognition of the different eating disorders presented (anorexia nervosa, bulimia nervosa and binge eating disorder) did not differ depending on the ethnicity of the person in the vignette (Sala, Reyes-Rodriguez, Bulik & Bardone-Cone, 2013). However, the disorder presented did affect response, with increased recognition of anorexia nervosa than the other disorders. The authors suggest this could be due to anorexia nervosa being a more

dramatic and easily recognised condition and binge-eating being more normalised in this population.

The impact of under-recognition of disordered eating patterns can have potentially detrimental impact on access to care. In the USA, Becker, Franko, Speck and Herzog (2003) explored ethnicity and access to care for different ethnic groups and found both Latin American and Native Americans were significantly less likely to receive a referral for further evaluation or care than their White counterparts. Minority participants were also less likely to be asked about eating disorder symptoms by the doctor, which in turn could adversely impact on their opportunity to access appropriate care. In part of the qualitative analysis by Becker et al. (2010), 6 respondents identified social stereotyping as having had a negative impact on help-seeking, such as concerns and symptoms being unrecognised or dismissed because of clinician expectations around the typical presentation of an eating disorder or what was seen as a social norms for that group.

A systematic review (Sinha & Warfa, 2013) looked at UK and USA studies to investigate the treatment of eating disorders among minorities. Their review of 12 studies found ethnic minorities were less likely to seek (and therefore receive) treatment than their White peers, and also less likely to be diagnosed and referred for specialist help. Referral bias was present in some studies.

Despite many years of these issues being identified, the literature in the area of ethnicity and eating disorders remains small. There is little doubt that stereotyping, whether an intentionally used tool or subconscious bias, has the potential to negatively impact on some groups than others. With the rise in research evidencing higher rates of disordered eating and eating disorders in minority groups, it is worrying that healthcare provider and community attitudes have not changed significantly over the years in line with this.

The areas discussed above have highlighted some vulnerability factors for those of a minority ethnic background. However, these select areas are by no means the only areas contributing to this vulnerability. For example, knowledge can play a key role in recognition and accessing help. In a study set in Sheffield, Chowbrey, Salway and Ismail (2012) highlighted the low awareness of eating disorders among older people from an ethnic minority background. In addition, the differing role of food in different cultures and ideal body image disparity within minority and between majority cultures were cited as some of the factors influencing the recognition of and response to eating disorders in minorities.

Although the impact of mental health stigma cannot be underestimated for the population in general, specifically for Asians there appear to be additional barriers to seeking support. Fortunately there is also evidence of increasing awareness among some clinicians who work with Asian populations as to the extent of stigma and denial of mental health problems and the need for cultural sensitivity and more creative solutions (e.g. Rastogi et al, 2014).

In the UK, guidance indicates increasing service providers' cultural competence may go some way to reducing the barriers minority service users face (e.g. DoH, 2003, NIMHE, 2003). In recognition of this, cultural competency is an expected requirement for mental health practitioners (IAPT, 2009), with the aim of increasing access and reducing inequalities in healthcare provision. There is suggestion that clinician sensitivity to the client's cultural background and awareness of issues around discrimination and stereotypes can influence treatment seeking behaviour (e.g. Thompson, Bazile & Akbar, 2004). NIMHE (2003) highlighted how, *"It is essential to improve the cultural competencies and capacity of the mental health workforce in order to overcome some of these difficulties, including organisational constraints, professional bias and personal prejudices"* (p. 30).

## **Rationale for this thesis**

*“General practitioners and other members of the primary care team are in a good position to identify patients with eating problems early” (NICE, 2004, p.73).*

There is limited literature available for primary care mental health service management of eating disorders or people with clinical features of disordered eating as part of their presentation and the decisions made for their care afterwards. There are also a limited number of UK-based studies looking at the impact of potential ethnic bias on decision-making. Some of the studies mentioned above show that recognition of eating disorders is variable and can also be dependent on the ethnic background of the client.

The present research was concerned with the perspective of mental healthcare providers in recognising disordered eating. In England, one of the largest providers of mental healthcare is IAPT (Increasing Access to Psychological Therapy), a government programme which started in 2006 aimed at increasing access to psychological therapy for common mental health conditions (e.g. depression and anxiety disorders) in working age adults. Since then it has expanded to working with a range of disorders, complexities and in different therapeutic modalities across the lifespan.

The therapeutic approach most commonly used in IAPT is Cognitive Behavioural Therapy (CBT). Services work at two levels, low-intensity (step 2 of the stepped care model) and high-intensity (step 3). At step 2, Psychological Wellbeing Practitioners provide CBT-based guided self-help and at step 3, patients can receive a range of therapies, mainly CBT but also Counselling and Interpersonal Therapy (IPT). Both levels are session-limited. Other professionals such as Clinical Psychologists are also involved in the programme. The present project was set up to encompass views across the range of clinical professionals who treat patients in IAPT services.



The author hoped to explore the clinical decision-making process of IAPT practitioners with a focus on ability to detect disordered eating patterns. She was also interested in any difference that was related to ethnicity. Such areas could help identify training needs for professionals, opportunities for service development, and ways to help professionals working with disordered eating.

It was hypothesised that mental healthcare providers would be:

1. Less likely to recognise clinical features of disordered eating in Asian patients (measured as categorising patient's primary problem as an eating disorder);
2. More likely to recommend more intensive or specialist treatment for the White patient; and
3. More likely to identify social or cultural factors as potential barriers in the Asian patient.

## Method

### Design

A between-participants experimental study with a 2 (ethnicity) by 3 (psychological disorder) condition design was used to explore clinical decision-making.

### Participants

A total of 156 participants were recruited, all of whom were clinical staff working in IAPT services. The majority of the participants were female (N = 121, 77.6%) with 35 males (22.4%), ranging in age from 24 to 65 years. Most participants identified their ethnicity as White (N = 143, 91.7%) with other ethnicities selected as Asian (N = 5, 3.2%), Black (N = 3, 1.9%), Mixed (N = 3, 1.9%) and 'Other' (N = 2, 1.3%; specified as Berber and North African).

A number of professional groups participated, consisting of Psychological Wellbeing Practitioners (PWPs; N = 41, 26.3%), Cognitive Behavioural Therapists (CBT Therapists; N = 39, 25.0%), High Intensity Therapists (HITs; N = 33, 21.1%), Psychological Therapists (N = 21; 13.5%), Counsellors (N = 12, 7.7%), Clinical Psychologists (N = 5, 3.2%), Primary Care Mental Health Workers (N = 4, 2.6%) and Psychology Practitioner (N = 1, 0.6%). Years of experience working in mental health ranged from 0 (trainee) to 39.

Recruitment took place via two main routes. One was the Northern IAPT Practice Research Network (PRN), a professional network for IAPT services in the North of England which aims to promote practice-based evidence to support treatment. The other was via contacting all 19 IAPT training courses in England, whose details were identified from the website of the British Association for

Behavioural and Cognitive Psychotherapies (BABCP). In addition, some informal recruitment took place by colleagues and supervisors of the researcher passing on information about the study to their own contacts in IAPT services, although these responses were a small minority.

To gain as wide a range of healthcare provider views as possible, the only inclusion criterion was that the workers be either a trainee or qualified worker in an IAPT service. This therefore excluded anyone (e.g. admin staff, some managers) who were not directly involved in making clinical decisions and providing patient care.

Participants did not receive direct payment for completing the questionnaire, but an incentive was available in that they were able to choose a charity they wanted to make a £1 contribution to from 3 options made available by the researcher.

Ethical permission to conduct this research was sought and granted from the University of Leeds School of Medicine Research Ethics Committee (SoMREC) on 10<sup>th</sup> October 2016, reference number MREC15-133 (Appendix A).

## **Vignettes**

Three vignettes were devised for use in this study (Appendix B). The development of these vignettes was influenced by the vignette studies of Currin et al. (2007), Gordon et al. (2006) and Sala et al. (2013), all of which looked at variables influencing decision making for people with an eating disorder.

In devising the vignettes, a base set of clinical features were chosen that illustrated a young woman in some distress. These features were typical of someone with a mood disorder plus some degree of body shape concern and were common to all 3 vignettes. To each version were added some additional features;

characteristics of anorexia nervosa in one version (potential restrictive eating pattern), characteristics of binge eating (and implicit purging) to another (potential binge eating pattern), and further mood disorder characteristics to the final, control vignette (depression and anxiety pattern). Table 1 below illustrates the similarities and differences between the vignette versions, with the differences between vignettes in bold.

*Table 1. Clinical features included in vignettes*

Symptom	Restrictive Eating Pattern	Binge Eating Pattern	Depression and Anxiety
Low mood	x	x	x
Social anxiety	x	x	x
Avoidance	x	x	x
Isolation	x	x	x
Disrupted sleep	x	x	x
Self-criticism	x	x	x
Low concentration	x	x	x
Tiredness	x	x	x
Irregular eating pattern	x	x	x
Self-criticism	x	x	x
Low concentration	x	x	x
Body shape concern	x	x	x
High standards	x	x	x
<b>Strict exercise routine</b>	<b>x</b>		
<b>Variable exercise routine</b>		<b>x</b>	<b>x</b>
<b>Thin appearance</b>	<b>x</b>		
<b>Weight loss</b>	<b>x</b>		
<b>Healthy weight</b>		<b>x</b>	<b>x</b>
<b>Reduced appetite</b>	<b>x</b>		<b>x</b>
<b>Low motivation</b>		<b>x</b>	<b>x</b>
<b>Episodes of overeating</b>		<b>x</b>	

All vignettes had the same patient story involving a 19-year old female named Zara who attended for an initial session with her mother. Zara's family, occupational and social details were consistent across the vignettes.

There were two versions of each vignette. The only difference between the versions was the picture presented at the top of the vignette to represent Zara. This photo was either of a young White girl or an Asian girl. The photos used in the vignettes are in Appendix C.

## **Measures**

The first part of the online survey was the participant information sheet (Appendix D). This provided information on the study, including what it involved, and invited participants to take part. It also covered areas that may cause concern such as confidentiality plus potential benefits of taking part. Contact details of the researcher and her supervisors were provided for any additional questions participants may have had. The page made clear that continuing with the survey meant the participant was acknowledging the information given and consenting to their information being used for the purposes of this research. They were also aware that responses could not be withdrawn once submitted due to the anonymous nature of the survey.

Next, brief demographic information was collected from participants including gender, age and ethnicity as well as information about the step they worked at and number of years' experience in mental health (Appendix E).

The questionnaire (Appendix F) asked clinicians to make a series of decisions. These included the likelihood of Zara having a diagnosis using a Likert type scale ranging from 0 (Not at all likely) to 10 (Extremely likely) for a list of 10 separate clinical conditions. They were then asked to select one diagnosis along with the most important symptoms that helped them come to this decision. They were also asked to select an initial treatment option, the list of which was taken from the primary care options used in the Currin et al. (2007) vignette where GPs were asked to select a treatment intervention, and the rest came from discussions from IAPT workers about the various options available to them. Finally,

participants were asked to identify any potential barriers in working with Zara, again using a Likert type scale ranging from 0 (Not at all likely) to 10 (Extremely likely). The opportunity for additional comments was provided at the end.

Participants were able to select which charity they want to make a donation to from 3 chosen by the researcher. These were Yorkshire Animal Shelter, SANDS (stillbirth and neonatal death charity) and the Samaritans.

### **Pilot**

To check the ecological validity of the vignettes, they were shown to 2 mental health practitioners, one an IAPT worker at step 3 and one in an eating disorder service. Both stated the presentations depicted in the vignettes appeared realistic and were typical of some people accessing their services. The practitioners also checked the face validity of the questionnaire, agreeing it appeared to measure what the researcher had intended it to, which was their clinical decision making and the ability to isolate and compare ethnic and cultural differences.

Both the pilot participants plus 8 trainee clinical psychologist peers from the researcher's year group trialled the questionnaire and minor changes to the instructions were made on the basis of this. On average it took approximately 10 minutes to complete, which was the information provided to participants.

### **Procedure**

Following an email proposal distributed by the IAPT Practice Research Network, all service heads and individual practitioners who replied to the researcher were sent brief information on the study with the web link to access the online survey. All IAPT training courses were contacted, asking if they would consider participating in the research and, if so, requesting they pass on the

information regarding the study, including web link, to all current and ex-trainees. This ensured viewpoints from clinicians across England would be gathered in the survey.

A reminder email was sent to all service leads and programme directors who had agreed to participate a few weeks after the initial invitation.

Data collection was via Bristol Online Surveys (BOS), a platform which allows for online access to and management of data whilst responses are being collected. Participants were able to access the online survey via a web link which was emailed to them. The web link had been set up to randomly allocate a questionnaire to each participant that clicked the 'take survey' button on the participant information sheet, which in turn meant the vignettes were randomly allocated.

All questions were set up to have a completion requirement. Therefore participants could not progress through the questionnaires without giving an answer to each question.

### **Data analysis**

All data were downloaded from Bristol Online Surveys into an SPSS (.sav) file to allow for analysis using IBM SPSS (version 24). Due to the completion requirement for each question, there was no missing data.

Tests for normality of data were carried out consisting of histograms, Q-Q plots, boxplots and the Kolmogorov-Smirnov statistic, which assesses the normality of a distribution of scores. This showed the data were appropriate for use in parametric tests.

To analyse the likelihood of an eating disorder, multivariate analysis of variance was conducted. There was homogeneity of covariance matrices, as assessed by Box's M test ( $p = .001$ ). There was homogeneity of variances, as assessed by Levene's Test of Homogeneity of Variance ( $p > .05$ ) for two of the three dependant variable groups. For this reason and also due to unequal sample sizes, Pillai's Trace was used for analysis. Post-hoc Tukey pairwise comparisons were run for the differences in mean eating disorder likelihood scores for each vignette.

To compare diagnosis selection, symptoms relevant to diagnosis decision and treatment recommendations, z-scores were calculated by ethnic group and also vignette version. Multinomial Logistic Regression was used to analyse differences in diagnosis and also recommended treatments by ethnicity. The Pearson chi-square statistic was non-significant ( $\chi^2(15) = 19.20$ ,  $p = .205$  for diagnosis and  $\chi^2(12) = 9.78$ ,  $p = .636$  for treatment), indicating the model fit the data well.

Potential barriers to treatment were analysed using a multivariate analysis of variance. Assumption in terms of sample size was met. There was homogeneity of covariance matrices, as assessed by Box's M test ( $p = .002$ ). There was also homogeneity of variances for all 4 dependent variables (scores on concerns in areas of family context, cultural factors, stigma and drop-out), as assessed by Levene's Test of Homogeneity of Variance ( $p > .05$ ).

Qualitative data in 'other areas of concern' and 'additional comments' sections was summarised by theme and analysed using content analysis as a method of systematically describing and quantifying the data.



## Results

### Likelihood of a disorder

Participants were asked to rate the likelihood of Zara having a particular disorder. Means and standard deviations of clinical problem ratings by vignette are shown in Table 2 below.

*Table 2. Mean (Standard Deviation) ratings of likelihood of disorder*

	Asian Vignette			White Vignette		
	REP (N=23)	BEP (N=20)	Control (N=30)	REP (N=31)	BEP (N=25)	Control (N=27)
Anorexia	3.36 (1.33)	2.38 (1.85)	2.14 (1.28)	4.13 (1.96)	3.32 (1.57)	3.00 (1.86)
Bulimia	2.90 (1.92)	2.76 (2.44)	1.70 (1.08)	2.88 (1.62)	3.22 (2.02)	2.65 (1.63)
BED	2.31 (1.30)	2.93 (1.44)	2.00 (1.66)	2.09 (1.35)	3.24 (1.82)	1.71 (1.05)
Depression	6.73 (2.39)	6.60 (1.98)	7.00 (2.18)	7.06 (1.77)	6.48 (2.10)	6.41 (2.06)
GAD	5.32 (2.23)	5.29 (2.91)	4.11 (2.30)	5.00 (2.17)	4.63 (2.41)	5.12 (2.09)
SAD	6.04 (2.14)	5.65 (2.32)	6.52 (2.15)	6.06 (2.21)	5.79 (2.21)	6.22 (1.85)
Panic	2.60 (1.45)	2.10 (1.45)	1.91 (0.87)	2.52 (1.93)	2.07 (1.49)	2.39 (1.09)
PD	1.38 (0.65)	1.75 (0.89)	1.53 (1.30)	1.63 (0.96)	1.80 (1.75)	1.75 (1.29)
OCD	2.00 (1.73)	2.29 (1.70)	1.60 (0.83)	1.86 (1.24)	1.77 (1.17)	2.28 (1.74)
Panic	2.60 (1.45)	2.10 (1.45)	1.91 (0.87)	2.52 (1.93)	2.07 (1.49)	2.39 (1.09)
Stress	4.53 (2.32)	5.06 (1.91)	4.42 (2.27)	4.59 (2.14)	4.50 (2.12)	3.72 (1.79)

***A higher score indicates increased likelihood of the disorder being present.***

**Key:** BEP = binge eating pattern, REP = restrictive eating pattern, Control = depression and anxiety, BED = Binge Eating Disorder, GAD = Generalised Anxiety Disorder, SAD = Social Anxiety Disorder, PD = Personality Disorder, OCD = Obsessive Compulsive Disorder.

A MANOVA was conducted with two independent variables (ethnicity and vignette version) and three dependent variables (scores on likelihood of anorexia nervosa, likelihood of bulimia nervosa, and likelihood of binge eating disorder).

The main effect of ethnicity on the combined dependent variables was not statistically significant,  $F(3, 148) = 2.57, p = .057, \text{partial } \eta^2 = .05$ . There was however a statistically significant main effect of the vignette version,  $F(6, 298) = 6.70, p < .0005, \text{partial } \eta^2 = .12$ . The interaction between ethnicity and vignette version on the combined dependent variables was not significant,  $F(6, 298) = 1.24, p = .288, \text{partial } \eta^2 = .02$ .

#### Ethnicity effects

Although the main effect of ethnicity on the combined dependent variables was not statistically significant, when considered separately in the univariate analysis, there was a statistically significant main effect of ethnicity on likelihood of anorexia nervosa,  $F(1, 150) = 6.94, p = .009, \text{partial } \eta^2 = .04$  (but not on likelihood of bulimia nervosa,  $F(1, 150) = .29, p = .593, \text{partial } \eta^2 = .002$  nor on likelihood of binge eating disorder,  $F(1, 150) = .001, p = .969, \text{partial } \eta^2 < .001$ ).

Likelihood of anorexia nervosa was rated higher in the White vignettes ( $M = 2.94, SD = 2.19$ ) than in the Asian vignettes ( $M = 2.05, SD = 1.76$ ), a statistically significant difference,  $t(154) = 2.76, p = .006$ .

#### Vignette effects

Univariate analysis showed a statistically significant main effect of vignette version for all 3 eating disorder diagnoses: for likelihood of anorexia nervosa,  $F(2, 150) = 14.95, p < .0005, \text{partial } \eta^2 = .17$ , for likelihood of bulimia nervosa,  $F(2, 150) = 3.13, p = .05, \text{partial } \eta^2 = .04$ , and for likelihood of binge eating disorder,  $F(2, 150) = 4.89, p = .009, \text{partial } \eta^2 = .06$ .

The score for likelihood of anorexia nervosa was 1.58, 95% CI [0.70, 2.46] higher in the restrictive eating pattern compared to the binge eating pattern, a statistically significant difference,  $p < 0.001$ . The score was 1.88, 95% CI [1.05, 2.71] higher in the restrictive eating pattern vignette compared to the control (depression and anxiety) vignette, again a statistically significant difference,  $p < .001$ . There was no difference in the likelihood score of the binge eating pattern vignette compared to the control (depression and anxiety) vignette (0.30, 95% CI [-.57, 1.17]).

None of the scores for likelihood of bulimia nervosa were statistically significant when the 3 vignette versions were compared. The score for likelihood of bulimia nervosa was .02, 95% CI [-0.91, 0.94] higher in the restrictive eating pattern vignette compared to the binge eating pattern vignette,  $p = .999$ . The score was 0.81, 95% CI [-0.11, 1.72] higher in the binge eating pattern vignette compared to the control (depression and anxiety) vignette,  $p = .095$ . The score for likelihood of bulimia nervosa was 0.83, 95% CI [-.04, 1.70] higher in the restrictive eating pattern vignette than in the control (depression and anxiety) vignette,  $p = .067$ .

The score for likelihood of binge eating disorder was significantly higher in the binge eating pattern vignette compared to the control (depression and anxiety) vignette (1.03, 95% CI [.26, 1.80]). There were no significant differences in scores between the other comparisons: the score was .56, 95% CI [-.22, 1.34] higher in the binge eating pattern vignette compared to restrictive eating pattern vignette, but this difference was not statistically significant,  $p = .209$ . The score was .47, 95% CI [-.26, 1.20] higher in the restrictive eating pattern vignette compared to the control (depression and anxiety) vignette; again this difference was not statistically significant,  $p = .288$ .

In summary, from the 3 potential eating disorder diagnoses, only anorexia nervosa varied significantly by ethnicity and was more likely to be diagnosed in the

White vignette. The likelihood of this diagnosis was also significantly higher when participants were presented with the restrictive eating pattern version of the vignette. Binge eating disorder was also significantly more likely to be chosen when participants were presented with the binge eating pattern vignette (but did not differ by Zara’s ethnicity).

## Diagnosis

When asked to select one diagnosis that they felt Zara was most likely to be diagnosed with, the participant selections combined across vignettes (REP, BEP and Control) are presented in Table 3.

*Table 3. Diagnosis selection by ethnicity (combined across vignettes)*

	Asian Vignette (N = 73)		White Vignette (N = 83)	
	N	%	N	%
Depression	36	49.3	38	45.8
Generalised Anxiety Disorder	13	17.8	11	13.3
Anorexia Nervosa	1	1.4	4	4.8
Social Anxiety Disorder	15	20.5	27	32.5
Bulimia Nervosa	4	5.5	0	0.0
Stress Disorder	4	5.5	3	3.6
<b>Totals</b>	<b>73</b>	<b>100</b>	<b>83</b>	<b>100</b>

The most commonly selected diagnosis for both ethnic groups was depression, followed by social anxiety disorder and generalised anxiety disorder; none of these differed significantly by ethnicity. In terms of eating disorders, no participant chose binge eating disorder as the most likely diagnosis. Anorexia nervosa was chosen slightly more often in the White vignette than the Asian one (4.8% vs 1.4% respectively), however frequencies for both were very low and the difference was not statistically significant. Bulimia nervosa was not chosen as a likely diagnosis in the White vignettes but was chosen by 5.5% of the participants

given the Asian vignette, a statistically significant difference ( $z = 2.16, p = .03$ ), although these are also small numbers.

Figures 1-3 show the most frequently selected diagnoses by the separate vignette versions and ethnic groups:

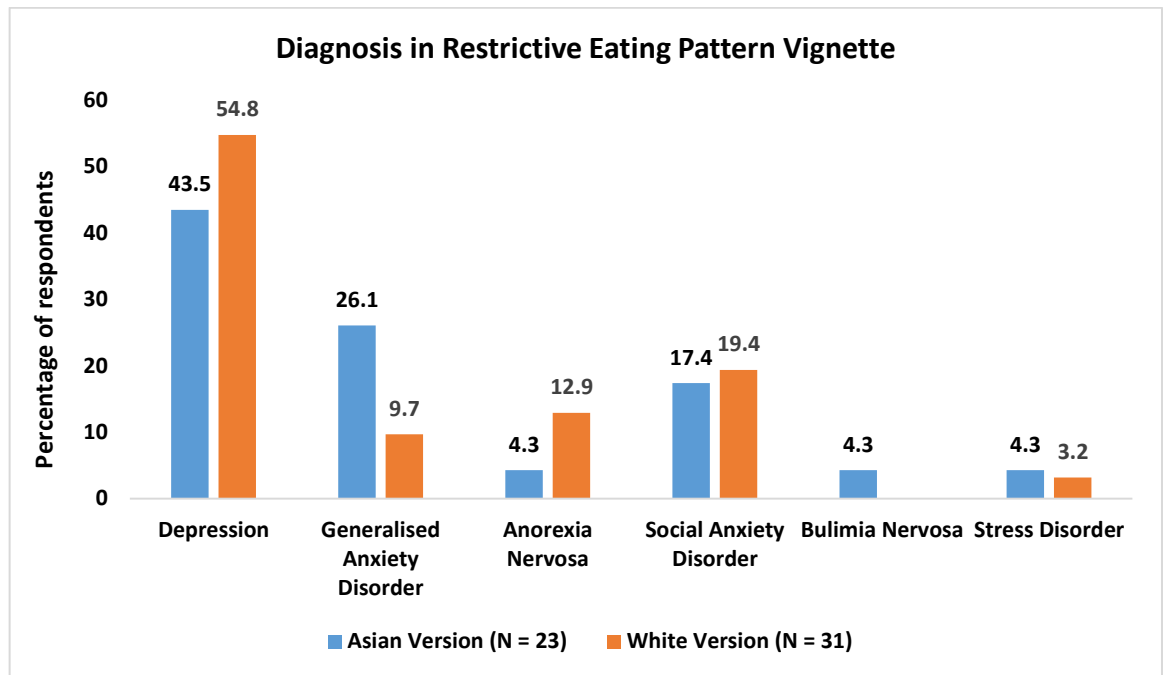


Figure 1. Diagnosis in REP vignette by ethnicity

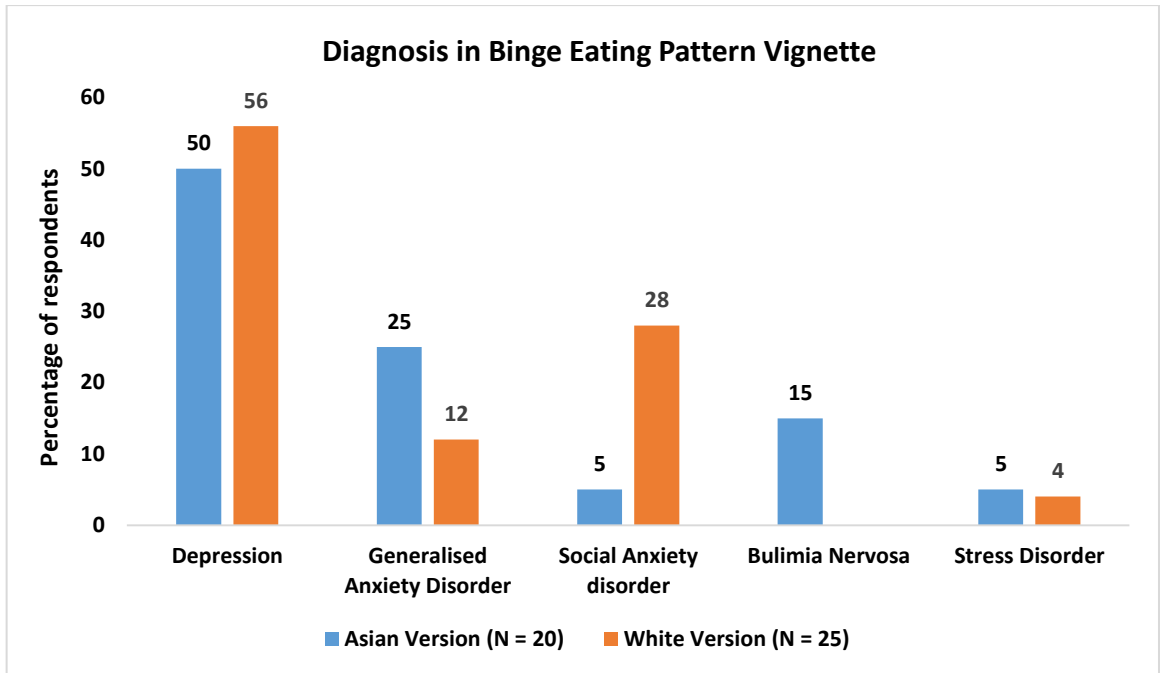


Figure 2. Diagnosis in BEP vignette by ethnicity

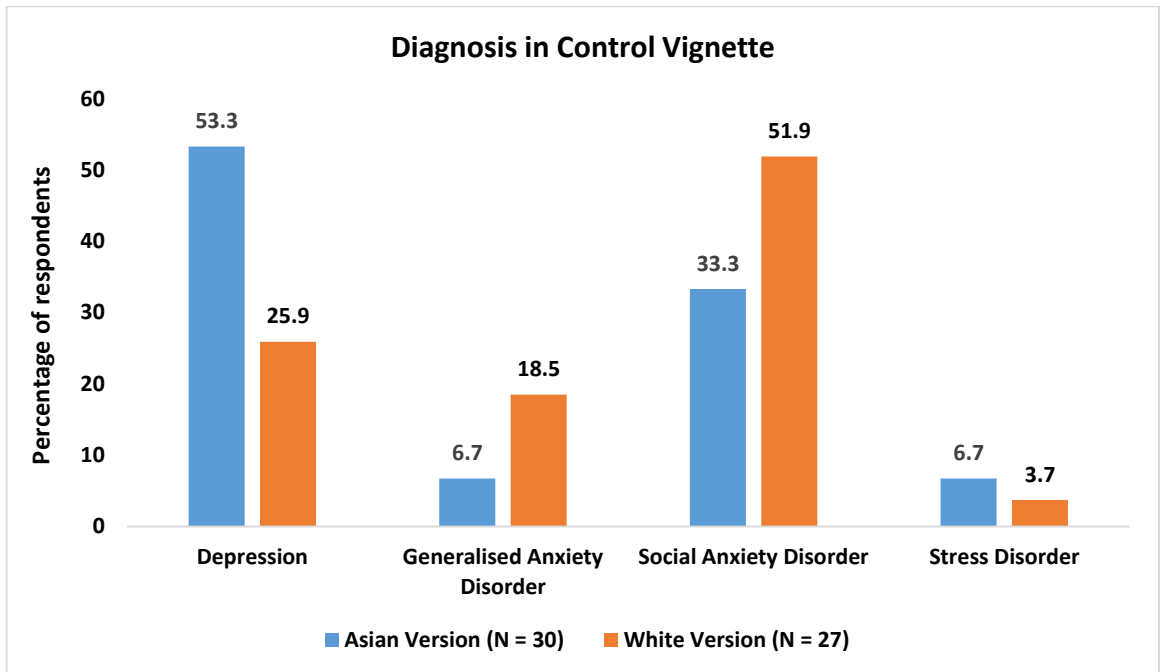


Figure 3. Diagnosis in control vignette by ethnicity

Multinomial logistic regression was conducted with diagnosis as the dependent variable, ethnicity as the independent variable and vignette version as the covariate. Both vignette version,  $\chi^2(5) = 14.37, p = .013$  and ethnicity,  $\chi^2(5) = 12.45, p = .029$  were statistically significant. Social anxiety disorder was the only diagnosis to differ significantly between vignette versions, Wald  $\chi^2(1) = 7.24, p = .007$ . As indicated in Figures 1-3 above, practitioners were more likely to select a diagnosis of social anxiety disorder in the control (depression and anxiety) vignette than the restrictive or binge eating patterns vignettes. No diagnosis differed significantly by ethnicity when broken down by separate disorder.

Across all vignettes, bulimia nervosa was chosen significantly more as a diagnosis in the Asian version of the vignette (albeit with very small numbers) and social anxiety was more likely to be chosen in the control vignette (with no significant difference by ethnicity).

### **Most relevant symptoms in decision-making**

In addition to diagnosis, participants were asked to choose up to 3 symptoms from a list of 13 that were most influential in their decision-making. Tables 4-6 summarise the symptoms selected in each vignette version by ethnic group.

### Restrictive eating pattern

Table 4. REP vignette symptom selection by ethnicity

Symptom selected	Asian Vignette (N = 23)	% of group	White Vignette (N = 31)	% of group
Low mood	8	34.8	17	54.8
Loss of appetite	6	26.1	7	22.6
Low motivation	5	21.7	8	25.8
Disrupted sleep	7	30.4	9	29.0
Exercise routine	3	13.0	4	12.9
Anxiety	12	52.2	8	25.8
Avoidance	10	43.5	10	32.3
Isolation	2	8.7	8	25.8
Body shape concern	2	8.7	2	6.5
Episodes of overeating	0	0.0	0	0.0
Self-criticism	10	43.5	16	51.6
Low concentration	0	0.0	3	9.7
Tiredness	2	8.7	1	3.2

Only anxiety differed significantly ( $z = 1.98, p = .048$ ) and was more likely to be selected as an important factor in the Asian vignette.

### Binge eating pattern

Table 5. BEP vignette symptom selection by ethnicity

Symptom selected	Asian Vignette (N = 20)	% of group	White Vignette (N = 25)	% of group
Low mood	10	50.0	13	52.0
Loss of appetite	2	10.0	2	8.0
Low motivation	5	25.0	3	12.0
Disrupted sleep	4	20.0	11	44.0
Exercise routine	2	10.0	0	0.0
Anxiety	6	30.0	10	40.0
Avoidance	8	40.0	11	44.0
Isolation	6	30.0	6	24.0
Body shape concern	3	15.0	0	0.0
Episodes of overeating	3	15.0	0	0.0
Self-criticism	9	45.0	17	68.0
Low concentration	2	10.0	1	4.0
Tiredness	0	0.0	1	4.0



Body shape concern ( $z = 2.00, p = .046$ ) and episodes of overeating ( $z = 2.00, p = .046$ ) were the only symptoms rated as significantly more important in the Asian vignette version.

Control (Depression and Anxiety)

*Table 6. Control vignette symptom selection by ethnicity*

<b>Symptom selected</b>	<b>Asian Vignette (N = 30)</b>	<b>% of group</b>	<b>White Vignette (N = 27)</b>	<b>% of group</b>
Low mood	17	56.7	12	44.4
Loss of appetite	3	10.0	3	11.1
Low motivation	9	30.0	4	14.8
Disrupted sleep	10	33.3	4	14.8
Exercise routine	1	3.3	0	0.0
Anxiety	12	40.0	15	55.6
Avoidance	10	33.3	16	59.3
Isolation	6	20.0	3	11.1
Body shape concern	1	3.3	3	11.1
Episodes of overeating	1	3.3	0	0.0
Self-criticism	18	60.0	14	51.9
Low concentration	0	0.0	5	18.5
Tiredness	2	6.7	2	7.4

Only the proportion of participants identifying low concentration differed significantly ( $z = -2.47, p = .014$ ) and was more likely to be selected as an important factor in the White vignette. This was not one of the most frequently selected symptoms.

## Treatment recommendations

Participants were asked to recommend an option as the first step towards treatment from a selection of 10. The following Tables (7-8) and Figures (4-5) summarise the treatment selection by vignette version and ethnicity.

### Restricted eating pattern

Table 7. Treatment selection in REP vignette

	<b>Asian Vignette (N = 23)</b>	<b>% of group</b>	<b>White Vignette (N = 31)</b>	<b>% of group</b>
No offer of treatment	-	-	-	-
Watchful waiting	-	-	-	-
Refer back to GP	-	-	-	-
Signposting to a voluntary sector organisation	-	-	-	-
Follow-up session	5	21.7	5	16.1
Guided self help - step 2	12	52.2	11	35.5
Cognitive Behavioural Therapy (CBT) - step 3	4	17.4	13	41.9
Interpersonal Therapy (IPT) – step 3	-	-	-	-
Counselling – step 3	2	8.7	2	6.5
Referral to a secondary or specialist mental health service	-	-	-	-

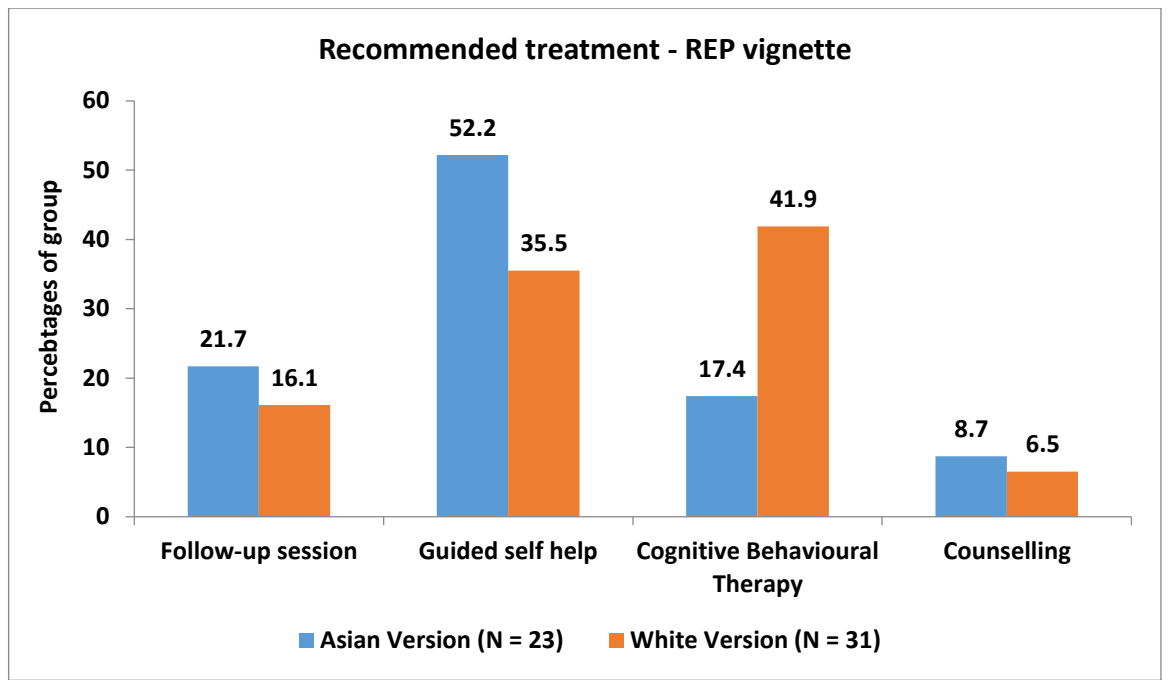


Figure 4. Recommended treatment by ethnicity in REP vignette

Step 2 guided self-help was most selected option in the Asian vignette, followed by a follow-up session and CBT at step 3. In the White version, CBT at step 3 was the most popular selection, with guided self-help at step 2 being second and follow-up session being third most selected option. None of these options differed significantly by ethnic group.

Binge eating pattern

Table 8. Treatment selection in BEP vignette

	Asian Vignette (N = 20)	% of group	White Vignette (N = 25)	% of group
No offer of treatment	-	-	-	-
Watchful waiting	-	-	-	-
Refer back to GP	-	-	-	-
Signposting to a voluntary sector organisation	-	-	-	-
Follow-up session	3	15.0	4	16.0
Guided self help - step 2	7	35.0	5	20.0
Cognitive Behavioural Therapy (CBT) - step 3	8	40.0	14	56.0
Interpersonal Therapy (IPT) – step 3	-	-	1	4.0
Counselling – step 3	2	10.0	1	4.0
Referral to a secondary or specialist mental health service	-	-	-	-

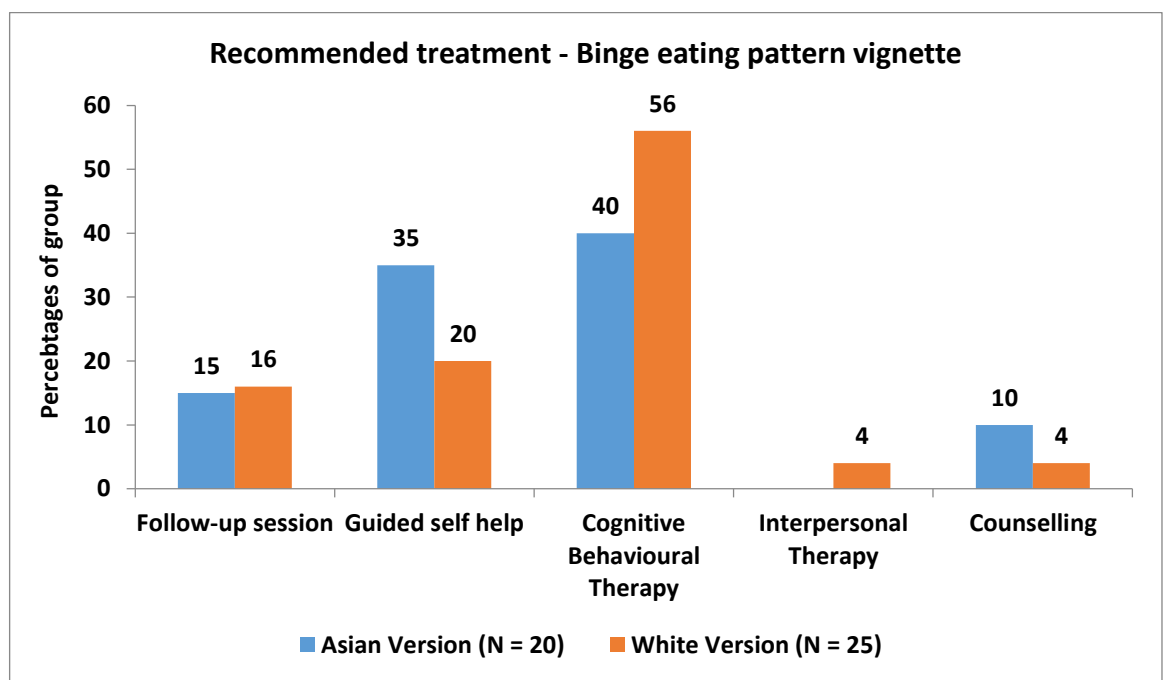


Figure 5. Recommended treatment by ethnicity in BEP vignette

The most popular choice for treatment in both versions of the vignette was CBT at step 3, followed by guided self-help at step 2 then a follow-up session. None of these options differed significantly by ethnic group.

#### Control vignette

In the control vignette, guided self-help at step 2 was the most recommended option of treatment in the Asian vignette, with CBT at step 3 the second. The opposite pattern was true of the White version. These differences were not significant.

Multinomial Logistic Regression was conducted with treatment as the dependent variable, ethnicity as the independent variable and vignette version as the covariate. Neither vignette version,  $\chi^2(4) = 9.19, p = .056$  nor ethnicity,  $\chi^2(4) = 7.69, p = .104$  were statistically significant, indicating neither had an significant impact on overall treatment selection. This also held true when the treatment options were considered separately.

Therefore it was concluded ethnicity did not significantly impact on treatment recommendation, regardless of vignette version presented.

#### **Social or cultural factors as barriers to treatment**

Participants were asked to rate the likelihood of a number of areas arising as concerns when working with Zara from a list of 10 separate potential concerns. Means and standard deviations of these ratings by vignette are shown below in Table 9.

Table 9. Mean (Standard Deviation) ratings of likelihood of concern

	Asian Vignette			White Vignette		
	REP (N=23)	BEP (N=20)	Control (N=30)	REP (N=31)	BEP (N=25)	Control (N=27)
Zara's family context	4.83 (2.31)	4.80 (2.24)	4.53 (2.43)	5.52 (2.14)	6.40 (1.76)	5.76 (1.96)
Cultural factors	4.57 (2.14)	4.85 (2.08)	3.83 (2.30)	3.17 (1.51)	3.83 (1.88)	4.46 (2.13)
Stigma	3.48 (1.76)	4.90 (2.10)	3.48 (1.99)	3.55 (2.06)	3.75 (1.94)	4.24 (2.13)
Drop-out	3.95 (1.56)	3.63 (1.86)	3.75 (2.14)	4.61 (2.11)	4.32 (1.57)	3.96 (1.54)
Own confidence	2.88 (2.09)	3.25 (2.65)	2.86 (2.05)	3.57 (2.25)	3.87 (2.60)	4.32 (2.80)
Zara's understanding	2.50 (1.15)	3.16 (2.01)	2.79 (1.44)	2.97 (1.59)	3.73 (2.35)	3.50 (2.13)
Zara's engagement	2.90 (1.38)	3.30 (2.16)	3.00 (1.65)	3.68 (1.62)	4.00 (2.33)	4.50 (2.57)
Family's understanding	4.57 (2.42)	5.25 (2.10)	4.54 (2.61)	5.03 (2.23)	5.58 (1.38)	4.88 (2.30)
Difficulties in stepping up referral	3.86 (2.35)	3.13 (2.19)	2.74 (1.91)	4.12 (2.54)	4.45 (2.16)	3.73 (2.51)
Access to further services	4.82 (2.79)	3.75 (2.46)	2.50 (1.43)	5.14 (2.69)	5.25 (2.45)	4.29 (2.60)

Prior to data collection and based on the literature, 4 areas were chosen to represent social and cultural factors among the 10 items – Zara's family context, consideration of cultural factors, stigma around accessing mental health services and drop-out.

A MANOVA tested the effects of ethnicity and vignette version on these four dependent variables (scores on concerns in areas of family context, cultural factors, stigma and drop-out).

The main effect of ethnicity on the combined dependent variables was statistically significant,  $F(4, 147) = 8.94, p < .0005$ , partial  $\eta^2 = .20$ . The main effect

of vignette version on the combined dependent variables was non-significant,  $F(8, 296) = 1.07, p = .388, \text{partial } \eta^2 = .03$ .

When considered separately, there was a significant effect of ethnicity on 3 of the dependent variables: family context  $F(1, 150) = 8.09, p = .005, \text{partial } \eta^2 = .05$ , cultural factors  $F(1, 150) = 4.00, p = .047, \text{partial } \eta^2 = .03$ , and dropout  $F(1, 150) = 5.35, p = .022, \text{partial } \eta^2 = .03$ . There was no significant effect of ethnicity on stigma  $F(1, 150) = .44, p = .506, \text{partial } \eta^2 = .003$ .

Family context was more of a concern in the White vignettes ( $M = 5.72, SD = 2.16$ ) than in the Asian vignettes ( $M = 4.70, SD = 2.31$ ), a statistically significant difference,  $M = 1.02, 95\% \text{ CI } [.32, 1.73], t(154) = 2.86, p = .005$ . There was no statistically significant difference regarding cultural factors being a concern between the Asian ( $M = 4.16, SD = 2.33$ ) and White ( $M = 3.51, SD = 2.07$ ) vignettes,  $M = .66, 95\% \text{ CI } [-.04, 1.35], t(154) = 1.87, p = .063$  (this was a different finding to the initial MANOVA analysis above and therefore reflects a very weak effect). Drop-out was more of a concern in the White vignettes ( $M = 4.27, SD = 1.84$ ) than in the Asian vignettes ( $M = 3.52, SD = 2.05$ ), a statistically significant difference,  $M = .75, 95\% \text{ CI } [.13, 1.36], t(154) = 2.394, p = .018$ .

There was a statistically significant interaction effect between ethnicity and version of vignette on the combined dependent variables,  $F(8, 296) = 2.27, p = .023, \text{partial } \eta^2 = .06$ . However when considered separately, there was no statistically significant interaction effect between ethnicity and version of vignette for any of the dependent variables: family context  $F(2, 150) = .58, p = .559, \text{partial } \eta^2 = .008$ , cultural factors  $F(2, 150) = 2.00, p = .139, \text{partial } \eta^2 = .03$ , stigma,  $F(2, 150) = 2.62, p = .076, \text{partial } \eta^2 = .03$ , or dropout  $F(2, 150) = .48, p = .619, \text{partial } \eta^2 = .006$ .

Overall, concern over family context and drop-out were rated as significantly more concerning for participants if they were working with Zara in the vignette versions where Zara was White.

## **Other areas of concern**

Participants were asked if there were any other areas that would be a concern when working with Zara.

### Restrictive eating pattern

For the Asian vignette version, 2 participants raised additional concerns in terms of possible dependency and that, *“Zara's presentation might be shoe-horned into one diagnostic approach to the detriment of her overall presentation.”* Therefore a formulation driven approach would be most suitable rather than a rigid IAPT diagnosis and package of care.

In the White version, 13 participants raised additional concerns in a number of areas. Two participants mentioned relationship with the GP, either in terms of liaison regarding medication or potential conflict with the GP's approach to the issue. Another 4 mentioned the overprotective/overinvolved role of Zara's mother and parental expectations or possible family coercion. Three participants would have liked opportunity for further assessment to gain a broader understanding of presenting difficulties. One felt motivation to change and Zara's beliefs about efficacy of treatment could be a potential barrier.

Disordered eating linked concerns were raised by 7 participants. These came under wanting to explore thinking around weight and image, concerns that physical health could deteriorate, *“If she does have an eating disorder not otherwise specified but her BMI was above 12 then I would be concerned about her being able to get the right support in a timely way in the area I work”*, impact of symptoms on therapy (e.g. tiredness, weight) and risk should weight increase, *“That based on this initial information mood would be overlooked and eating disorder would be focused on as is always the case”*, monitoring weight / missed meals and referral to specialist services.



### Binge eating pattern

In the Asian vignette, 4 participants raised additional concerns in terms of risk assessment, family dynamics and Zara's lack of confiding in others, discussions around referring on to a specialist service if Zara had an eating disorder/disordered eating and Zara's mother being involved in sessions and what this could mean for further treatment.

Ten participants had further concerns in the White vignette version. These included further investigation around thoughts and risk or any trauma, helpfulness of outcome measures, engagement and communication with family, and physical or interpersonal difficulties. One mentioned concerns over the new social group Zara is socialising with and need to check out she is not being groomed or radicalised.

Four participants mentioned perfectionism or self-esteem, with one linking esteem to family and influence and another to eating difficulties. Other mentioned body image and changes in eating and exercise regime, *"I would want to gather more information about Zara's eating/attitude to her body/attitude to food as I would be concerned about potential eating disorder. One of my concerns would be that she may be concealing information from the therapist, and possibly be in denial about eating issues - I would be concerned about this as her self-reports around this seem to differ from her mother."*

### Control (depression and anxiety)

Two participants chose to comment that there were no further areas of concern they had, with one stating, *"I would not be concerned in working with Zara. Her presentation appears common to primary care at both step 2 and 3."*

Five participants raised additional concerns about working with Zara in the Asian vignette. Two of these related to family interference in therapy, one related to issues of perfectionism and self-esteem as these areas are not strictly covered by

diagnosis or protocol in IAPT, another raised Zara's stage of development and how much is 'normal' and another felt there may be undisclosed issues.

Ten participants raised additional areas of concern when working with Zara in the White vignette. Interestingly, half of these related to concerns in area of body image/eating even though this vignette had not been devised specifically around eating disorder symptoms as the others had. Participants mentioned wanting to ask more questions to ascertain whether Zara had an eating disorder, checking her BMI with the GP and further exploring eating and weight, the "*development of anorexia nervosa as a coping mechanism*", and isolation due to impact of disordered eating, eating problems and link to body image, stepping up if patient had an eating disorder, and assessment for body dysmorphic disorder.

Others raised concern about potential risk and also about Zara's perfectionism as well as prioritising symptoms to work on and ensuring that the therapeutic relationship remains.

This open-ended question brought up many concerns which appeared to fall in the areas of systemic factors in terms of family and other professionals and services, concerns around Zara's health and relationships, and interpersonal factors.

### **Anything else**

At the end of the survey participants were given space for any further comments they would like to add. Thirty-eight participants commented across all 6 vignettes. Fifteen participants commented on requiring more information to aid in assessment, formulation, identifying patient goals and devising a treatment plan, 11 participants shared ideas for a potential treatment plan, 3 commented on their hypotheses of the presentation and 2 commented on concerns around mum being present in sessions. Other comments related to decisions made in light of service / own experience, Zara's age as a concern, and patient choice as a guide to treatment.

## Discussion

There is limited UK literature in the areas this thesis focussed on - clinical decision-making in mental health practitioners, differences by ethnicity and disordered eating. This thesis set out to explore whether mental health practitioners were less likely to recognise clinical features of an eating disorder in Asian patients, more likely to recommend more intense or specialist treatments in White patients, and more likely to identify social or cultural factors as barriers in Asian patients. Using a vignette design of a young girl named Zara, 2 variables were manipulated: ethnicity (Asian or White) and clinical condition (restricted eating, binge eating, depression and anxiety). The same questionnaire was given to all participants.

### Summary of results

#### Recognition of clinical features of an eating disorder

Ethnicity had a significant impact on whether participants thought Zara was likely to have anorexia nervosa. The White version of Zara was more likely to be considered as having anorexia nervosa than the Asian version. There was no significant difference in terms of likelihood of bulimia nervosa or binge eating disorder. When asked to select only one diagnosis, bulimia nervosa was chosen significantly more in the Asian version of the vignette, however the numbers making this selection were very small (4 in Asian version vs 0 in White). Anorexia nervosa was chosen more in the White vignette but this difference was not significant and was also based on very small numbers. The hypothesis that mental health practitioners were less likely recognise symptoms of disordered eating in the Asian patient was therefore partially upheld.

The first finding, with the White version of Zara was more likely to be considered as having anorexia nervosa than the Asian version, was in keeping with

some of the literature in this area on recognition of eating disorders (Gordon et al., 2006). Specifically, that there may be biased perceptions of what a 'typical' presentation of an eating disorder or disordered eating looks like (i.e. White female). That this difference was apparent in the restrictive eating pattern only is interesting. This could be due to the symptoms in the restricted eating pattern vignette being more 'typical' or 'severe' and those in the binge eating pattern being less so. Sala et al. (2013) found that the type of disorder affected response, with increased recognition of anorexia nervosa than bulimia nervosa or binge eating disorder, which may be more normalised in this population as opposed to the more physically dramatic effects that can be seen in disorders like anorexia nervosa.

Bulimia nervosa was more recognised in the Asian vignette, which suggests that the relationship between ethnicity and eating disorders is far from clear-cut. It may be that some disorders (anorexia nervosa-type) are viewed as more of a 'White' problem and some are viewed with less of a stereotypical lens. Due to low numbers in this condition it is difficult to interpret this result more meaningfully, which indicates an area of future research.

#### Most relevant symptoms in diagnosis selection

There were also some significant differences in clinical features rated as important in coming to diagnostic decisions between the ethnic groups and vignette versions. Anxiety was higher rated in the Asian vignette in the restrictive eating pattern vignette, as was body shape concern and episodes of overeating in the binge eating pattern vignette. Some features are therefore likely to be given more importance in making clinical decisions and there is evidence of this differing depending on ethnicity of patient presented. This could lead to differing diagnoses being given as different symptoms are weighted differently, which could also explain the differences in diagnoses given in each vignette. This could have a further impact on the decisions regarding treatment and access to further care, such as being less likely to receive a diagnosis or be referred for specialist help

(Abbas et al., 2010; Becker et al., 2010; Ratan et al., 1998; Sinha & Warfa, 2013; Waller, 2009).

### Treatment recommendations

In the restricted eating pattern, the most popular treatment option for Zara was guided self-help at step 2 if she was Asian and CBT at step 3 if she was White, however this difference was not significant. There was also no significant difference in treatment recommendations by ethnicity in the binge eating pattern or control vignettes. There was no evidence in this study that treatment recommendations differed significantly between vignette versions. Therefore, the hypothesis that mental health practitioners would be more likely to recommend more intensive or specialist treatment for the White patient was not upheld.

The pattern of Zara in the White vignette being offered more intensive intervention (CBT at step 3) more often than Zara in the Asian vignette could be linked to perceived severity of disorder attributed to each vignette version then being matched to level of perceived appropriate intervention. Currin et al. (2007) also found a non-significant result that GPs differed in recommended treatment dependant on patient ethnicity. It may be a larger sample size would allow for these patterns to be explored in more depth.

### Social and cultural factors

Although all 10 areas presented as options to participants could be considered areas of concern/barriers, for the purposes of this thesis 4 areas were focussed on (Zara's family context, consideration of cultural factors, stigma around accessing mental health services and drop-out). Family context was significantly more likely to be rated as a concern in the White vignette, as was drop-out. There was there not a significant effect of ethnicity on stigma. In terms of cultural factors, initial analysis showed a significant different by ethnicity in terms of being more of a concern in Asian vignettes however this was a weak effect which was

then lost in follow-up analysis. Perhaps a larger sample size would have increased the strength of this effect. The version of the vignette did not make a significant difference to ratings. The final hypothesis, therefore, that mental healthcare providers would be more likely to identify social or cultural factors as potential concerns in the Asian patient, was not upheld. In fact, the opposite was true; social and cultural factors were rated as more of a concern in the White version of the vignette.

This finding was surprising, especially in light of the literature in these areas. This finding could be due to a number of different reasons. Access to primary mental health care is inequitable in the UK, with ethnic minority clients less likely to access mainstream services (Fernando, 2005; Kovandzic et al., 2011). It is realistic to assume most practitioners see a majority of White British patients, therefore their ratings on the social and cultural factors in the White vignette reflect their experiences with this population as opposed to an Asian one. The majority of participants were also White, and it is feasible they felt more comfortable regarding the family circumstances of the White vignette versions and less so of the Asian versions.

Another area of consideration is the areas chosen to represent social and cultural factors. The author chose 4 factors to represent social and cultural factors, with the others presented to disguise the main factors of interest. However, it is realistic to assume that some or all of the other 6 factors participants were able to rate (own level of confidence in working with Zara's difficulties, Zara's understanding of psychological therapy, Zara's engagement with your approach, Zara's family's understanding of mental health difficulties, difficulties in stepping referral up, access to further services) could also be considered important social and cultural barriers. Although not analysed further, there were noticeable differences in ratings between the different versions of the vignettes in these areas.

Social desirability may also have played a role in ratings. This section of the questionnaire, which explicitly presents options around culture (difference) could have alerted participants to be more cautious in their responses. Survey questions that are more sensitive in nature can give inaccurate responses due to participant social desirability bias and perhaps need for approval from the researcher or others (Krumpal, 2013). Although there was no direct interaction between the author and participants (apart from the few who directly emailed the author), this bias can exist in surveys online the same as paper ones. A meta-analysis showed there was no significant difference in social desirability whether a survey was online or on paper (Dodou & de Winter, 2014). Especially for the Asian vignette, this bias could have led participants to be more conservative in their rankings and consider their answers more carefully. One participant later showed there was an awareness of the presence of personal biases and how these can be due to ethnic factors e.g. *“I also wouldn't want to assume there might be family/cultural issues simply because Zara is not white - there may be, but there may not.”*

#### Other areas of concern

Participants brought up other areas that could be potential concerns when working with Zara. These ranged from systemic factors such as family dynamics and involvement of other professionals and services, concerns around Zara's health and relationships, and interpersonal factors. Some of these are also discussed further in the next section.

#### **Methodological considerations for future studies**

The studies that have been conducted in the areas of clinical decision-making and stereotyping in relation to eating disorders have favoured a vignette method. For clinical presentations, it is difficult to imagine an alternative that

would allow for a patient's context and various factors to be presented in a realistic and life-like way.

*'Vignette designs provide a feasible alternative to a range of other methodologies (e.g., record review, interview, focus group, diary, survey) and are well suited for almost any question about the judgments and decision-making processes of individuals in general, and of professionals in particular'* (Evans et al., 2015, p164). In their research, which also covered the utility and real world applications of vignette designs, Evans et al. (2015), drawing on a wide range of historical and current research in the area, made a number of recommendations for vignette content, including length, narrative style, present tense, neutrality with regards to cultural and socioeconomic factors, and being relatable and plausible. The present researcher tried to keep these in mind as far as possible when devising the vignettes for this project.

However, there is always room for development of methodology. Participants were given additional space to document any comments or concerns. Some of this feedback could be used to develop areas of vignettes and questionnaires if a similar study was to be conducted in future.

It was apparent that many clinicians struggled with the forced choice aspects of the questionnaire, which was understandable as the ambiguous nature of some symptoms could mean the perceived problem could be across diagnoses, meaning it would prove difficult to identify one:

*"The forced kraelinian choice is a fallacy and whilst this is how services are commissioned, this is not how clinicians operate, assessment and treatment are intrinsically linked and thus further information is required to properly formulate her presenting problem and consider the next steps."*



More flexibility and less limited options may help in gaining a broader understanding of factors involved in clinical decision-making. There was also a degree of caution regarding eating disorders, and awareness they may be present even if not made explicit:

*“Also, as I've worked with eating disorders, I'm aware they can still be there even if it seems on the 2nd session that they're not.”*

Further information about external factors may help give more of a systemic understanding to Zara's formulation, for example, more information on family dynamics and the involvement of other healthcare providers i.e. GP.

In the restricted eating pattern vignette, a few participants mentioned disordered eating linked concerns. As low numbers chose an eating disorder diagnosis (compared to the most popular choice of depression and anxiety disorders), it is possible this may have been due to some hesitation or uncertainty over these diagnoses, therefore participants chose to stick to the 'safer' options. It may also point to a lack of health literacy in this area which could be due to training or professional practice. As eating disorders are not generally in the remit of IAPT services, they may therefore may not be covered in depth in IAPT training courses.

This study employed a between-subjects design rather than a within-subjects one. An advantage of this approach would have been the ability to compare differences in decisions and recommendations within individual practitioners, which could have highlighted areas such as personal preferences and differences in training. However, as personal areas such as clinical decision-making and sensitive ones in terms of cultural factors were being gauged, showing more than one vignette would have alerted the participant to the true nature of the study, especially if one vignette happened to have a picture of a White girl on it and the other an Asian girl.

This was also one of the reasons for not taking a qualitative approach to explore some areas in more depth. In qualitative data collection the researcher is the instrument through which data is collected and analysed and for this particular researcher, this could have been a barrier. The researcher is from an ethnic minority background, and it is likely there would have been a high degree of social desirability bias and caution when answering any questions in the area of culture, which would have significantly impacted on the representativeness and accuracy of data gathered.

This is not to say a qualitative approach would not be of benefit in exploring this area. A different methodology (e.g. semi-structured interviews with participants) would have allowed a greater degree of exploration of process and meaning and generated richer data from which potentially more meaningful analysis could have been derived.

### **Clinical implications**

Almost half of all responses to selection of one diagnosis chose depression, followed by an anxiety disorder. Recognition that Zara may have an eating disorder was fairly limited, e.g. of the participants in the restrictive eating pattern vignette, only 4.3% in the Asian version and 12.9% in the White version chose anorexia nervosa as a diagnosis. In the binge eating pattern, no participants chose binge eating disorder as a diagnosis however 15% chose bulimia nervosa as a diagnosis in the Asian version.

This may be because depression and anxiety disorders are the most commonly seen range of presentations in IAPT services so practitioners are primed to look for symptoms that fit presentations they see most regularly. Alternatively, perhaps because there were many clinical features present that could come under a number of psychological disorders, the ones most commonly that these are attributed to in services were selected.

Most IAPT services are not set up to work with eating disorders, and it is often an area that is seen as more specialist. As rates of disordered eating are estimated to be much more common than those meeting full criteria for diagnosis (Nasser, 2006), it is feasible many such cases are presenting to primary care mental health services but due to less obvious symptoms, not being recognised. This leaves a gap where improving mental health literacy via training in recognising and picking up signs and symptoms would be helpful. This would allow for earlier detection and options to consider suitable interventions at an earlier stage than if unhelpful patterns of thinking and behaviour were not intervened with.

Tareen et al. (2005) had found Asian females were less likely to receive a diagnosis of anorexia nervosa and this may in part be due to different symptom profiles between ethnic groups. If recognition of disordered eating or a potential eating disorder is based on a standard list of symptoms, there may be a bias for increased recognition in the population those lists are based on (i.e. White, Western). This could leave those from different cultural or ethnic backgrounds at a disadvantage, where their expression of distress is less likely to be recognised due to it not fitting the set norm. Training in awareness of difference expressions of distress could help address this need.

Cultural competency is a term that is often used in guidelines when speaking about working with diverse populations. Despite being in popular use, there appears to be little consensus on what a term such as cultural competence is. One definition used to describe culturally competent practice is by the Improving Access to Psychological Therapies (IAPT) initiative on their website:

*“Culturally competent practice refers to an ability to respond to a range of diverse experiences and identities of clients and which through adaptation should strive to meet the diversity of life experiences, lifestyles and backgrounds clients have. Culturally competent practice does not require firsthand experience or knowledge of a client's experience. Instead, it is the ability of a practitioner to*

*understand cultural influences on their own perceptions, i.e. perceptions structured by and through their own cultural experiences, beliefs and influences.”*

Explicit in this statement is the need for practitioners to be able to reflect on their own backgrounds and belief systems and understand its influence on their way of seeing the world, especially in relation to those from a different background. The majority of the participants in this study were White. Literature in the area of mental health professionals' awareness of White privilege is limited and there is some evidence of differing levels of awareness in relation to this (e.g. Ancis & Szymanski, 2001; Gushue, 2004). There may be a need for this to be given more prominence in training courses and in teaching around diversity issues.

### **Strengths**

One of main strengths of this thesis is that it is one of the first UK studies to look at clinical decision-making in mental health practitioners. As far as the author is aware, there have been no studies looking at ethnic differences and disordered eating or eating disorders with this population in the UK before. This study provides a foundation from which further studies can be developed. What is also apparent is that the assumptions and also research findings of the American and British studies in the area of biases in decision-making do not wholly apply to this specific population of mental health practitioners. Focusing on this population allowed this study to analyse a diverse group of professionals who work in mental health services rather than medical services, and also in the cultural context of Britain. It cannot be assumed that other Western countries would have similar culture or training practices.

There was some evidence that the vignettes developed portrayed eating disorder symptomatology well. For example, anorexia nervosa was rated higher as a likely disorder significantly more in the restrictive eating pattern vignette

compared to the binge eating and control patterns. Likelihood of binge eating disorder was also significantly higher in the binge eating pattern vignette compared to the control vignette (but not the restricted eating pattern vignette). There were enough clinical features presented for there to be an indication of a potential diagnosis of an eating disorder.

This study focussing exclusively on mental health practitioners is also a strength, as these are the professionals that would be expected to assess and provide therapeutic input to people with a wide range of mental health problems. Therefore, it may be expected that they would be more able to pick up subtle differences in presentation and favour different factors in coming to clinical decisions than do other professionals.

### **Limitations**

One of the limitations of this study was the different sample sizes in the study groups. It was expected with the randomisation software that there would be roughly even numbers in each group. However, this was not the case. One hundred and fifty-six participants completed the questionnaire. Across the 6 vignettes, the smallest group had 20 participants and the largest had 31. One hundred and seven potential participants clicked on the web link but did not complete the survey, and the majority of these did not go past the first page (participant information page). Even if all non-completers had participated, there was still noticeable variation in group sizes, with the smallest group having 32 participants and the largest 52. This suggests that either the randomisation software did not work very well or alternatively, that the total number of participants that completed the survey was not large enough to even out the groups. A larger sample size in future may help even out these differences.

Another limitation concerned the participant pool. The two avenues for recruitment pursued (the IAPT Practice Research Network in the North of England and IAPT training courses across the country) meant the survey was available to a wide range of services and practitioners across the country. However, the majority of courses either did not reply or did not email the invitation to their current and ex-trainees. As location was not gathered from participants, there is no way of knowing whether views from across the country or only select areas were gathered, meaning whether the decisions represented in the survey are representative of UK IAPT practitioners as a whole is somewhat uncertain. A more targeted recruitment method or gathering information on location would help with this.

The generalisability of the sample to IAPT mental health practitioners is unknown. There are no comparators in terms of the size of the IAPT workforce and as this questionnaire was distributed via the Practice Research Network, training courses, different services and also via colleagues, it was not feasible to keep track of where it went. It is likely the sample could be skewed in some ways e.g. more culturally competent practitioners participating, more experience of eating disorders, etc.

It would have also been helpful to relate characteristics of the participants to decisions they made, to see if there were differences in decisions by professional group, level of training, years of mental health experience or ethnic background. In this study participants were grouped according to the vignette version they were allocated to; further research into differences between participants would be beneficial. This is discussed further below.

## **Recommendations for further research**

Further research into decision-making by mental health providers is needed. Not just for comparative purposes, but to better understand this area. There will always be a degree of subjectivity in clinical decisions, but identifying the underlying factors involved and variables most important to practitioners will further help identify patterns of deciding, helpful and potentially unhelpful ones. If there is evidence to suggest practitioners are less likely to pick up an eating disorder or disordered eating in some ethnic groups, this could lead to targeted training so that those under-recognised populations are not missed and are given equitable access to help.

IAPT is one of the main mental health service providers across England and Wales, however it is not the only one. Comparisons may be useful across a range of mental healthcare providers, especially if some are used to treating individuals with suspected or diagnosed eating disorders, which many IAPT services are not.

Comparing mental health providers may be beneficial in terms of gauging their assumptions and decision-making. As was evidenced in the participant information mentioned earlier, IAPT services encompass a wide range of professionals, all of whom will have different degrees of training and qualification. It may be helpful to compare between these. As the Hay et al. (2007) study showed, mental health literacy can vary by professional group. It is feasible then that some professionals, due to training, experiences and reflective practices, are more able to identify eating disorders or disordered eating patterns than others.

This was not done in this thesis for 2 reasons. Firstly, due to the lack of research in the areas of clinical decision-making in mental practitioners and also impact of patient ethnicity, it was decided to focus on these areas. And secondly, almost three quarters of the participants came from a CBT or CBT informed clinical roles (Psychological Wellbeing Practitioners, CBT Therapists and High Intensity

Therapists), which is the dominant model used in IAPT. Larger numbers of professionals from other disciplines would make for more meaningful comparisons, which is another reason to also recruit from non-IAPT services in future. Additional characteristics, such as gender of clinician and area of work, may also show differential patterns of decision-making. In the Currin et al. (2007) study, gender was not found to significantly impact on results however location of practitioner was in terms of treatment recommendations.

Although ethnicity of client has both been found to be related to identification of and subsequent referral for help (Gordon et al., 2002; Gordon et al., 2006), this evidence is not unanimous (Sala et al., 2013). Few studies have looked at the impact of clinician own ethnicity on clinical decision-making (Gordon et al, 2002, found a non-significant difference in a student sample), with this research being concentrated in the medical field. For example, Ewen et al. (2015) found biases in medical student's ways of talking about Aboriginal patients and their subsequent priorities for them (although not unequal treatment decisions). Sellers et al. (2016) found significant differences in nurses from an ethnic minority background's use of race in clinical decision-making compared to their White peers, which they attributed partly to higher degrees of racial self-awareness in minority nurses.

It would, therefore, also be useful to consider clinician ethnicity and if this is linked to decision-making in mental health practitioners. In this sample, however, over 90% of participants were White and there were very small numbers of other ethnic groups. A more ethnically diverse participant pool would help in making comparisons in this area.

*“When people make judgments about individual members of stereotyped groups, they may use the stereotyped expectation as a standard or reference point”* (Biernat, Collins, Katzarska-Miller & Thompson, 2009, p. 16). Research considering



ethnic or cultural background is fairly limited but increasingly important in light of the shifting demographics of service users that access services. Although there was some evidence found in this study that ethnicity makes a difference in eating disorder diagnosis, it would be beneficial for further research in this area to explore this issue and what additionally may be required for mental health practitioners to be doing to minimise the impact of any biases on patient care.

## **Conclusions**

There is evidence of ethnic differences in how eating disorders are viewed and treated. Additional barriers exist for people of minority ethnic backgrounds, in the case of this thesis, Asians. This study found ethnic differences in eating disorder diagnoses given and also social and cultural barriers in young females. The White vignette was more likely to be given a diagnosis of anorexia nervosa and concern over family context and drop-out were also more likely to be concerns in the White vignette (there was a weak effect for cultural factors being more of a concern in the Asian vignettes however this was lost in follow-up analysis).

This was the first study conducted in decision-making in IAPT practitioners and it is recognised there is much to build on. It is possible there were a number of factors at play, such as potential bias, social desirability bias, the demographics practitioners see in their daily work and cultural competency of practitioners. This study highlighted there are definite areas where it would be useful and beneficial to explore further in terms of practitioner ability to recognise patterns of disordered eating and eating disorders in people from different backgrounds, and understand how people may also present differently.

Vignettes provide a useful tool to describe real-life clinical situations and some of the feedback received from participants could be used to further develop scenarios which could more flexibly incorporate practitioner views.

It would be beneficial for further research to be conducted in this area, with more comparators between professionals (training, experience, ethnicity, etc) and services. It would also be helpful to ensure procedures are in place to allow for generalisability checks with the IAPT workforce, which itself is very diverse in terms of locations, professionals, interventions offered, etc.

Cultural sensitivity training or reflective practice on personal biases should be encouraged to help practitioners become more aware of this area and be able to work to minimise any potentially negative impact on patients.

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## Appendix A – SoMREC Ethical Approval Letter



**UNIVERSITY OF LEEDS**

**Faculty of Medicine and Health Research Office  
School of Medicine Research Ethics Committee (SoMREC)**

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10 October 2016

Miss Afshan Chaudary  
Trainee Clinical Psychologist  
Doctor of Clinical Psychology Programme  
Leeds Institute of Health Sciences  
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Dear Afshan

Ref no: **MREC15-133**

Title: **Clinical Decision-Making in Mental Health Services (Healthcare Provider Recognition of Disordered Eating in White and Asian Patients)**

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you.

<i>Document</i>	<i>Version</i>	<i>Date Submitted</i>
MREC15-133 - Final ethics form	3.0	29/09/2016
PIS and Consent Webpage	2.0	29/09/2016
PIS - version 3	3.0	29/09/2016
Email regarding distribution to IAPT PRN	1.0	29/09/2016
IAPT PRN project proposal - Version 1	1.0	18/08/2016
Post-study statement to participants - Version 1	1.0	18/08/2016
Emails to participants - Version 1	1.0	18/08/2016
MREC15-133 email re alternative title of study	1.0	15/07/2016
Vignette 1 - restrictive pattern - Asian	1.0	14/07/2016
Vignette 2 - restrictive pattern - White	1.0	14/07/2016
Vignette 3 - depression and anxiety - Asian	1.0	14/07/2016
Vignette 4 - depression and anxiety - White	1.0	14/07/2016
Vignette 5 - binge eating symptoms - Asian	1.0	14/07/2016
Vignette 6 - binge eating symptoms - White	1.0	14/07/2016
End of survey page	1.0	14/07/2016
Charitable donation page	1.0	14/07/2016
Questionnaire - page 2 of 2	1.0	14/07/2016

Questionnaire - page 1 of 2	1.0	14/07/2016
Demographic Information	1.0	14/07/2016

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information ([fmhuniethics@leeds.ac.uk](mailto:fmhuniethics@leeds.ac.uk))

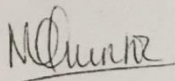
Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

*Please note:* You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.

Yours sincerely



**Dr Naomi Quinton**  
Co-Chair, SoMREC, University of Leeds

*(Approval granted by Co-Chair Dr Naomi Quinton on behalf of committee)*

## **Appendix B – Vignettes**

### **Restrictive eating pattern**

Zara is a 19-year old college student referred to your service by her GP. You meet with her on two occasions.

In the initial meeting, Zara is accompanied by her mother who stays present for the duration of the session. Her mother describes the family's increasing concern for Zara over the past year. She is worried about Zara's mood and describes how Zara has stopped spending time with the family and isolates herself in her room whenever she is not at college or working in her part-time job as a waitress.

In gathering background information, you find out Zara lives with both her parents, younger brother and grandmother near the centre of Bradford. She started college last year and initially struggled to make new friends, eventually finding acceptance with a group who she had not gone to school with. Some of her friends are preoccupied with how they look and Zara's mother feels Zara is more self-conscious about her body since becoming part of this group. Zara says this is not true and that she was always self-conscious, it's just her mother has only noticed it now. Zara acknowledges her mood has been lower over the past year but is unable to identify any trigger for this. When asked how she manages her low moods, she says exercise helps and she has had a very regular exercise routine for the past couple of years that she makes sure to stick to, increasing as and when she feels it's appropriate to. This is the only thing which appears to help lift her mood. Zara's mother disagrees and says she thinks Zara exercises too much and uses it as an excuse to avoid spending time with family and friends. She is also concerned that Zara has lost weight and is unsure if she eats enough, suspecting she may be skipping meals. Zara becomes upset at this and says she does try to eat but she

doesn't feel hungry much anymore and doesn't like people constantly talking about it. Zara does look quite thin but not worryingly so.

Following the initial session, you offer a follow-up appointment, which Zara attends by herself after college. She says she had wanted to say more in the last session but had not felt able to in front of her mother for fear of upsetting her further.

Zara shares becoming increasingly anxious in social situations which have led to her avoiding going out with friends, not just due to low mood as her mother suggested. The last time she went out, a friend made a comment about how different she looked which Zara had taken as a criticism of her appearance. Zara acknowledges she can be hard on herself and finds it difficult when she does not achieve the high standards she expects of herself.

Zara says she is mostly concerned about her performance in college and is tearful explaining her grades have been slipping over the past few months. She describes struggling to concentrate in class most of the time and feeling tired a lot. This could be explained by her lack of a regular sleep pattern. Zara described lying awake worrying about college most nights, which in turn led to her being tired during the day and needing to take a nap in the afternoons. Her eating pattern also appears to be irregular and she admits to not having eaten anything so far that day, stating she felt too tired and stressed but that she was planning on getting some fish and chips on the way home.

When asked if she confides in anyone about her difficulties, Zara says sometimes she talks to her grandmother, who is patient and understanding. She does not feel able to speak with her parents as she feels they overreact and don't understand things from her perspective. She has tried to talk to a couple of friends but thinks her problems are minor in comparison to theirs so feels guilty for sharing.

## **Binge eating pattern**

Zara is a 19-year old college student referred to your service by her GP. You meet with her on two occasions.

In the initial meeting, Zara is accompanied by her mother who stays present for the duration of the session. Her mother describes the family's increasing concern for Zara over the past year. She is worried about Zara's mood and describes how Zara has stopped spending time with the family and isolates herself in her room whenever she is not at college or working in her part-time job as a waitress.

In gathering background information, you find out Zara lives with both her parents, younger brother and grandmother near the centre of Bradford. She started college last year and initially struggled to make new friends, eventually finding acceptance with a group who she had not gone to school with. Some of her friends are preoccupied with how they look and Zara's mother feels Zara is more self-conscious about her body since becoming part of this group. Zara says this is not true and that she was always self-conscious, it's just her mother has only noticed it now. Zara acknowledges her mood has been lower over the past year but is unable to identify any trigger for this. When asked how she manages her low moods, she says exercise helps and she has an exercise schedule she tries to stick to, but this varies depending on mood and motivation levels. This is the only thing which appears to help lift her mood. Zara's mother disagrees and says she thinks Zara sometimes exercises too much and uses it as an excuse to avoid spending time with family and friends. She is also concerned about Zara's weight and is unsure if she eats enough, however acknowledges sometimes Zara's appetite is larger than her fathers. Zara becomes upset at this and says she does try to eat healthily but her appetite is variable and she doesn't like people constantly talking about it. Zara appears to be of a healthy weight.

Following the initial session, you offer a follow-up appointment, which Zara attends by herself after college. She says she had wanted to say more in the last session but had not felt able to in front of her mother for fear of upsetting her further.

Zara shares becoming increasingly anxious in social situations which have led to her avoiding going out with friends, not just due to low mood as her mother suggested. The last time she went out, a friend made a comment about how different she looked which Zara had taken as a criticism of her appearance. Zara acknowledges she can be hard on herself and finds it difficult when she does not achieve the high standards she expects of herself.

Zara says she is mostly concerned about her performance in college and is tearful explaining her grades have been slipping over the past few months. She describes struggling to concentrate in class most of the time and feeling tired a lot. This could be explained by her lack of a regular sleep pattern. Zara described lying awake worrying about college most nights, which in turn led to her being tired during the day and needing to take a nap in the afternoons. Her eating pattern also appears to be irregular and she says due to stress and tiredness she eats little in the day but sometimes eats more than usual in the evenings.

When asked if she confides in anyone about her difficulties, Zara says sometimes she talks to her grandmother, who is patient and understanding. She does not feel able to speak with her parents as she feels they overreact and don't understand things from her perspective. She has tried to talk to a couple of friends but thinks her problems are minor in comparison to theirs so feels guilty for sharing.

### **Depression and anxiety (control vignette)**

Zara is a 19-year old college student referred to your service by her GP. You meet with her on two occasions.

In the initial meeting, Zara is accompanied by her mother who stays present for the duration of the session. Her mother describes the family's increasing concern for Zara over the past year. She is worried about Zara's mood and describes how Zara has stopped spending time with the family and isolates herself in her room whenever she is not at college or working in her part-time job as a waitress.

In gathering background information, you find out Zara lives with both her parents, younger brother and grandmother near the centre of Bradford. She started college last year and initially struggled to make new friends, eventually finding acceptance with a group who she had not gone to school with. Some of her friends are preoccupied with how they look and Zara's mother feels Zara is more self-conscious about her body since becoming part of this group. Zara says this is not true and that she was always self-conscious, it's just her mother has only noticed it now. Zara acknowledges her mood has been lower over the past year but is unable to identify any trigger for this. When asked how she manages her low moods, she says exercise helps and she has an exercise schedule she tries to stick to, but this varies depending on mood and motivation levels. This is the only thing which appears to help lift her mood. Zara's mother disagrees and says she thinks Zara sometimes exercises too much and uses it as an excuse to avoid spending time with family and friends. She is also concerned about Zara's weight and is unsure if she eats enough. Zara becomes upset at this and says she does try to eat regularly and healthily but her appetite is variable and she doesn't like people constantly talking about it. Zara appears to be of a healthy weight.

Following the initial session, you offer a follow-up appointment, which Zara attends by herself after college. She says she had wanted to say more in the last session but had not felt able to in front of her mother for fear of upsetting her further.

Zara shares becoming increasingly anxious in social situations which have led to her avoiding going out with friends, not just due to low mood as her mother suggested. The last time she went out, a friend made a comment about how different she looked which Zara had taken as a criticism of her appearance. Zara acknowledges she can be hard on herself and finds it difficult when she does not achieve the high standards she expects of herself.

Zara says she is mostly concerned about her performance in college and is tearful explaining her grades have been slipping over the past few months. She describes struggling to concentrate in class most of the time and feeling tired a lot. This could be explained by her lack of a regular sleep pattern. Zara described lying awake worrying about college most nights, which in turn led to her being tired during the day and needing to take a nap in the afternoons. Her eating pattern also appears to be irregular. Zara explains that due to stress and tiredness, how much and at what time she eats can vary from day to day but she does try and make herself eat.

When asked if she confides in anyone about her difficulties, Zara says sometimes she talks to her grandmother, who is patient and understanding. She does not feel able to speak with her parents as she feels they overreact and don't understand things from her perspective. She has tried to talk to a couple of friends but thinks her problems are minor in comparison to theirs so feels guilty for sharing.



**Appendix C – Vignette photos**



## **Appendix D – Participation Information Sheet**

### **Clinical Decision-Making in Mental Health Services**

#### **Invitation to take part**

You are invited to take part in an online survey looking at clinical decision-making by mental healthcare providers. The aim of this research is to gain further insight into decision making processes by healthcare providers. This study is interested in how you make your decision, what factors you take into account when making it, and whether some variables are more important than others.

This study will form part of the doctoral thesis for Afshan Chaudary, Psychologist in Clinical Training, University of Leeds.

#### **Why am I being invited to take part?**

You are being invited as you work for a service that sees people with a range of different mental health problems and presentations. The researcher is interested in the views of those that are involved in direct therapeutic work with a range of conditions. Both qualified staff and trainees are invited to participate.

#### **Why is this study important?**

There is very limited information on clinical decision making, especially in mental health practitioners. This study has the potential to identify useful patterns within clinical decision making and inform further research in this area.

#### **What does it involve?**

You will be presented with a vignette describing a patient's presenting problem. Following this, you will be asked to answer a few questions about your opinion of the patient's problem and potential treatment options.

It is estimated this questionnaire will take approximately 10 minutes to complete.

#### **Do I have to take part?**

No. Participation in the study is entirely voluntary and the time commitment it would take to participate is appreciated. You will not be asked for any reason if you choose not to participate. Due to the anonymous nature of the survey, responses cannot be withdrawn once they are submitted.

#### **What will you do with the information I provide?**

To ensure your confidentiality, you will not be asked to provide any identifiable information such as your name or location of your service. Data collected will be stored in a confidential manner and the final report will only use general

descriptors. Quotes may be used in the final report, however these will be used to identify themes and the researcher will be careful that no identifiable information is used.

**Will you share my information with others?**

Only the researcher and her supervisors will have access to the data collected from the study. This will not be shared with anyone else and will be stored securely on the University of Leeds computers.

**What are the possible benefits of taking part?**

The results of the study will help identify factors important in decision making by mental healthcare providers. It will also inform further research in this area and potentially identify any training needs.

**What are the drawbacks of taking part?**

Apart from approximately 10 minutes of your time, nothing!

**Who has reviewed the study?**

Ethical approval to carry out this project has been granted by the School of Medicine Research Ethics Committee at the University of Leeds.

**Contact details**

If you have any questions or concerns about this study, please contact Afshan Chaudary, Trainee Clinical Psychologist, by emailing [umacha@leeds.ac.uk](mailto:umacha@leeds.ac.uk) or writing to her at University of Leeds, Doctor of Clinical Psychology Programme, Charles Thackrah Building, 101 Clarendon Road, Leeds LS2 9JT.

You can also contact the research supervisors Professor Andrew Hill on [A.J.Hill@leeds.ac.uk](mailto:A.J.Hill@leeds.ac.uk) / Tel. 0113 343 2734 and Dr Suzanne Heywood-Everett on [S.M.Heywood-Everett@leeds.ac.uk](mailto:S.M.Heywood-Everett@leeds.ac.uk) / Tel. 0113 343 4832.

***To thank you for your participation if you choose to complete the survey, a charitable donation of £1 will be made for each of the first 250 completed questionnaires. The researcher has chosen 3 charities and you are able to select which one you would like your donation to be sent to after you have completed the questionnaire.***

**By continuing with this survey you are acknowledging the information above and also consenting to your data being used for research.**

**Please click on the button below to take the survey.**

## Appendix E – Demographic information

**What gender do you consider yourself to be?**

Male  Female

**Age** \_\_\_\_ (free text box)

**How would you class your ethnicity?**

White  Asian  Black  
 Chinese  Mixed  Other \_\_\_\_\_(free text box)

**Job title:** \_\_\_\_\_ (free text box)

**What step do you work at?** \_\_\_\_\_ (free text box)

**Years working in mental health (including training)** \_\_\_\_\_ (free text box)

**What step do you work at?**

Step 2 (low intensity)  
 Step 3 (high intensity)  
 Step 4  
 Step 5  
 Other \_\_\_\_\_ (free text box)

## Appendix F – Questionnaire

1. How likely do you think it is that Zara has the following clinical problem?

**Depression**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Generalised Anxiety Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Anorexia Nervosa**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Social Anxiety Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Bulimia Nervosa**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Panic Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Personality Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Obsessive-Compulsive Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Binge Eating Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Stress Disorder**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

2. Which one disorder do you think Zara is most likely to be diagnosed with? [Drop box with options from qu. 1]

3. Which symptoms were most relevant in helping you come to this decision?

Please select a maximum of 3 from the list below.

- Low mood
- Loss of appetite
- Low motivation
- Disrupted sleep
- Exercise routine
- Anxiety
- Avoidance
- Isolation
- Body shape concern
- Episodes of overeating
- Self-criticism
- Low concentration
- Tiredness

4. Which of the following would you recommend as a first step towards treatment?

Please choose one of the following options.

- No offer of treatment
- Watchful waiting
- Refer back to GP
- Signposting to a voluntary sector organisation
- Follow-up session
- Guided self help - step 2
- Cognitive Behavioural Therapy (CBT) - step 3
- Interpersonal Therapy (IPT) – step 3
- Counselling – step 3
- Referral to a secondary or specialist mental health service

5. How likely do you think it is that the following would arise as concerns if you were working with Zara?

**Own level of confidence in working with Zara's difficulties**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Zara's understanding of psychological therapy**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Zara's engagement with your approach**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Zara's family context**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Zara's family's understanding of mental health difficulties**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Consideration of cultural factors**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Stigma around accessing mental health services**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Difficulties in stepping referral up**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Access to further services**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

**Drop-out**

0 1 2 3 4 5 6 7 8 9 10  
Not at all likely Extremely Likely

*Are there any other areas that would concern you? (free text box)*

6. Is there anything else you would like to add? *(free text box)*